6-10-87
Vol. 52 No. 111
Pages 21931-22286

Wednesday
June 10, 1987

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DEPARTMENT OF AGRICULTURE

7 CFR Part 2

Revision of Delegations of Authority

AGENCY: Office of the Secretary, USDA.

ACTION Final rule.

SUMMARY: This document amends the delegations of authority from the Secretary of Agriculture and General Officers of the Department to delegate authority to develop and implement a research and pilot project program for the development of supplemental and alternative crops; and the authority to conduct a research and development program to formulate new uses for farm and forest products.

EFFECTIVE DATE: June 10, 1987.

FOR FURTHER INFORMATION CONTACT: Robert L. Siegler, Deputy Assistant General Counsel, U.S. Department of Agriculture, Washington, DC (202) 447-6035.

SUPPLEMENTARY INFORMATION: The delegations of authority of the Department of Agriculture are amended (1) to delegate to the Assistant Secretary for Science and Education, and the Administrator of the Cooperative State Research Service, the authority to develop and implement a research and pilot project program for the development of supplemental and alternative crops pursuant to section 1473D of the National Agricultural Research, Extension, and Teaching Policy Act of 1977, as amended by the Food Security Act of 1985; (2) to delegate to the Administrator of the Extension Service the authority to provide technical assistance to farm owners and operators, marketing cooperatives, and others in the development and implementation of said research and pilot project program; and (3) to delegate to the Assistant Secretary and the Administrator of the Cooperative State Research Service, the authority to conduct a research and development program to formulate new uses for farm and forest products pursuant to section 1436(b) of the Food Security Act of 1985.

This rule relates to internal agency management. Therefore, pursuant to 5 U.S.C. 553, notice of proposed rulemaking and opportunity for comment are not required and this rule may be made effective less than 30 days after publication in the **Federal Register.**

Further, since this rule relates to internal agency management, it is exempt from the provisions of Executive Order 12291. Finally, this action is not a rule as defined by the Regulatory Flexibility Act, and thus, is exempt from the provisions of that Act.

List of Subjects in 7 CFR Part 2

Authority delegations (Government agencies).

PART 2—DELEGATIONS OF AUTHORITY BY THE SECRETARY OF AGRICULTURE AND GENERAL OFFICERS OF THE DEPARTMENT

Accordingly, Part 2, Subtitle A, Title 7, Code of Federal Regulations is amended as follows:

1. The authority for Part 2 continues to read as follows:

Authority: 5 U.S.C. 301 and Reorganization Plan No. 2 of 1953, unless otherwise noted.

Subpart C—Delegations of Authority to the Deputy Secretary, the Under Secretary for International Affairs and Commodity Programs, the Under Secretary for Small Community and Rural Development, and Assistant Secretaries

2. Section 2.30 is amended by adding new paragraphs (a)(86) and (a)(87) to read as follows:

§ 2.30. Delegations of authority to the Assistant Secretary for Science and Education.

* * * * *

(a)* * *

(86) Develop and implement a research and pilot project program for the development of supplemental and alternative crops (7 U.S.C. 3319d).

(87) Conduct a research and development program to formulate new uses for farm and forest products (7 U.S.C. 1632(b))

* * * * *

Subpart N—Delegations of Authority by the Assistant Secretary for Science and Education

3. Section 2.107 is amended by adding new paragraphs (a)(24) and (a)(25) to read as follows:

§ 2.107 Administrator, Cooperative State Research Service.

(a) * * *

(24) Develop and implement a research and pilot project program for the development of supplemental and alternative crops (7 U.S.C. 3319d).

(25) Conduct a research and development program to formulate new uses for farm and forest products (7 U.S.C. 1632(b)).

4. Section 2.108 is amended by adding a new paragraph (a)(27) to read as follows:

§ 2.108 Administrator, Extension Service.

(a) * * *

(27) Provide technical assistance to farm owners and operators, marketing cooperatives, and others in the development and implementation of a research and pilot project program for the development of supplemental and alternative crops (7 U.S.C. 3319d).

* * * * *

For Subpart C.

Dated: June, 4, 1987.

Richard E. Lyng,

Secretary of Agriculture.

For Subpart N.

Dated: June 2, 1987.

Orville G. Bentley,

Assistant Secretary for Science and Education.

[FR Doc. 87-13179 Filed 6-9-87; 8:45 am]

BILLING CODE 3410-01-M

DEPARTMENT OF COMMERCE

Economic Development Administration

13 CFR Part 309

[Docket No. 70359-7059]

Nonrelocation; Financial Assistance Requirements

AGENCY: Economic Development Administration (EDA), Commerce

ACTION: Interim rule with request for comments.

SUMMARY: This rule amends EDA's nonrelocation rule to provide that where a relocation of jobs from one area to another has occurred more than forty eight [48] months after the date of project approval and after September 15, 1986, such relocation of jobs will not be considered a violation of the rule. Violations which occurred prior to September 15, 1986, would not be waived. In addition, the rule is amended to change the rate of interest to be charged when a recipient of Federal assistance does not comply with EDA's nonrelocation rule and EDA terminates the financial assistance. The interest rate to be charged will be the rate published by the Treasury Department as the Current Value of Funds Rate for use in Federal debt collection and discount evaluation rather than the *Wall Street Journal* rate as now cited in 13 CFR 309.3(m) (51 FR 32629, September 15, 1986). For calendar year 1987, this rate is 7 percent.

DATE: Effective date June 10, 1987.

Comments by: August 10, 1987.

ADDRESS: Send comments to Eugenie E. Foster, Chief Counsel, Economic Development Administration, U.S. Department of Commerce, Herbert C. Hoover Building, 14th Street between Pennsylvania and Constitution Avenues, NW., Room 7001, Washington, DC 20230.

FOR FURTHER INFORMATION CONTACT: James F. Marten, Deputy Chief Counsel, Economic Development Administration, U.S. Department of Commerce, Herbert C. Hoover Building, 14th Street between Pennsylvania and Constitution Avenues, NW., Room 7001, Washington, DC 20230, (202) 377-5441.

SUPPLEMENTARY INFORMATION: Title 13 CFR 309.3(f) is being amended by adding a statement that grants made under Titles I, IV and IX and section 301(f) of Title III of the Act which were approved prior to November 13, 1985, are subject to the requirements of 50 FR 46749, November 13, 1985. However, violations of the rule in effect prior to November 13, 1985, which occurred prior to that date, would not be waived.

EDA is amending 13 CFR 309.3—nonrelocation at paragraph (m) by changing the interest charged for debts owing to EDA on account of violation of the nonrelocation rule to the Treasury Current Value interest charged under the Debt Collection Act, as published in the **Federal Register.**

Under Executive Order 12291 the Department must judge whether a regulation is "major" within the meaning of section 1 of the order and therefore subject to the requirement that a Regulatory Impact Analysis be prepared. This regulation is not major because it is not likely to result in an annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Accordingly, neither a preliminary nor final Regulatory Impact Analysis has to be or will be prepared.

This rule is exempt from all requirements of 5 U.S.C. 553 including notice and opportunity to comment and delayed effective date, because it relates to public property, loans, grants, benefits and contracts.

No other law requires that notice and opportunity for comment be given for this rule.

Accordingly, the Department's General Counsel has determined and so certified to the Office of Management and Budget, that dispensing with notice and opportunity for comment is consistent with the Administrative Procedure Act and all other relevant laws.

However, because the Department is interested in receiving comments from those who will benefit from the amendment, this rule is being issued as interim final. Public comments on the interim rule are invited and should be sent to the address listed in the "ADDRESS" section above.

Comments received by August 10, 1987, will be considered in promulgating a final rule.

Since notice and an opportunity for comment are not required to be given for this rule under section 553 of the APA (5 U.S.C. 553) or any other law, under sections 603(a) and 604(a) of the Regulatory Flexibility Act (5 U.S.C. 603(a), 604(a)), no initial or final Regulatory Flexibility Analysis has to be or will be prepared.

This rule does not contain a collection of information for purposes of the Paperwork Reduction Act (Pub. L. 96-511).

List of Subjects in 13 CFR Part 309.

Community development, Grant programs—community development, Loan programs—community development, Penalties.

For the reasons set out in the preamble, Title 13, Chapter III, Part 309 is amended as set forth below.

PART 309—GENERAL REQUIREMENTS FOR FINANCIAL ASSISTANCE

1. The authority citation for Part 309 continues to read as follows:

Authority: Sec. 701, Pub. L. 89-136; 79 Stat. 570 (42 U.S.C. 3211); Sec. 1-105, Department of Commerce Organization Order 10-4, as amended (40 FR 56702, as amended.

2. Section 309.3 is amended by revising paragraphs (f) and (m) to read as follows:

§ 309.3 Nonrelocation.

* * * * *

(f) Grants made under Titles I, II, and IX and section 301(f) of Title III of the Act, which were approved from November 13, 1985, through September 15, 1986, are governed by EDA's interim final rule on nonrelocation published in the **Federal Register** on November 13, 1985 (50 FR 46749). All other grants approved prior to September 15, 1986, will be governed by the rule as revised on that date, provided however, that any violation of the nonrelocation rule in effect prior to that date, which occurred prior to that date, will not be waived.

* * * * *

(m) When EDA determines that these requirements have been violated, EDA will terminate for cause the financial assistance made available by EDA. The recipient will be obligated to repay to EDA the full amount of that financial assistance, plus interest from the date determined by EDA upon which the violation occurred, at the U.S. Treasury Current Value of Funds Rate.

Dated: June 3, 1987.

Orson G. Swindle, III,

Assistant Secretary for Economic Development.

[FR Doc. 87-13251 Filed 6-9-87; 8:45 am]

BILLING CODE 3510-24-M

SECURITIES AND EXCHANGE COMMISSION

17 CFR Part 211

[Release No. SAB-70]

Staff Accounting Bulletin No. 70

AGENCY: Securities and Exchange Commission.

ACTION: Publication of Staff Accounting Bulletin.

SUMMARY: This staff accounting bulletin expresses the staff's views relative to the accounting and balance sheet presentation for non-recourse debt that is collateralized by lease receivables and/or the related leased assets. It also deletes certain interpretations published in Staff Accounting Bulletin No. 52 that are no longer relevant because of accounting standards adopted by the Financial Accounting Standards Board.

DATE: June 5, 1987.

FOR FURTHER INFORMATION CONTACT: James R. Bradow, Office of the Chief Accountant (202–272–2130); or Howard P. Hodges, Jr., Division of Corporation Finance (202/272-2553), Securities and Exchange Commission, Washington, DC 20549.

SUPPLEMENTARY INFORMATION: The statements in Staff Accounting Bulletins are not rules or interpretations of the Commission nor are they published as bearing the Commission's official approval. They represent interpretations and practices followed by the Division of Corporation Finance and the Office of the Chief Accountant in administering the disclosure requirements of the Federal securities laws.

June 5, 1987.

Shirley E. Hollis,

Assistant Secretary.

PART 211—[AMENDED]

Part 211 of Title 17 of the Code of Federal Regulations is amended by adding Staff Accounting Bulletin No. 70 to the table found in Subpart B.

Staff Accounting Bulletin No. 70

The staff hereby adds Section R to Topic 5 and deletes Topic 5–I of the staff accounting bulletin series. Topic 5–R discusses the staff's views relative to the accounting and balance sheet presentation for non-recourse debt that is collateralized by lease receivables and/or the related leased assets. Topic 5–I relates to recognition of gains on terminations of overfunded defined benefit pension plans, the accounting for which is now addressed by FASB Statement No. 88.

Topic 5: Miscellaneous Accounting

* * * * *

R. Accounting for Non-recourse Debt Collateralized by Lease Receivables and/or Leased Assets

* * * * *

Facts: A registrant borrows on a non-recourse basis and assigns to the lender a security interest in lease receivables and/or the related leased assets.

Question: Can the lease receivables and non-recourse debt be removed from the balance sheet either by (a) accounting for this transaction as a sale or assignment of the lease receivables or (b) by offsetting the lease receivables and non-recourse debt?

Answer: No. The staff believes that under existing Generally Accepted Accounting Principles this type of transaction should be accounted for as a borrowing and, as such, the resultant debt should be reflected in the registrant's balance sheet.[1] Paragraph 20 of FASB Statement No. 13, as amended by FASB Statement No. 77, indicates that the "sale or assignment of a lease or of property subject to a lease accounted for as a sales-type or direct financing shall not negate the original accounting treatment accorded the lease" and that "any profit or loss on the sale or assignment shall be recognized at the time of the transaction." [2] However, the staff understands that the FASB intended the term "assignment" as used in that Statement to represent the transfer from one party to another of a direct interest in a contractual right or property, and not a security interest in a right or property. Non-recourse borrowing arrangements that involve the assignment [3] of a security intrerest in a lease and/or property subject to lease therefore, do not result in recognition "as if" a sale had occurred under the provisions of paragraph 20 of FASB Statement No. 13.[4]

Further, the accounting literature [5] generally does not allow non-recourse debt and lease receivables and/or the related leased assets to be offset in the balance sheet. This was recently reaffirmed by the staff of the FASB in Technical Bulletin No. 86–2, "Accounting for an Interest in the Residual Value of a Leased Asset." [6]

The guidance in this Bulletin should be applied in financial statements issued after the issuance of this Staff Accounting Bulletin. Such financial statements should reflect the full amount of non-recourse borrowings and lease receivables outstanding. The staff strongly encourages application of this SAB to prior balance sheets for comparability. However, it will not insist on such treatment providing full disclosure is made in the financial statements and management's discussion and analysis of the effects on prior year's financial statements (including disclosure of the amount of non-recourse borrowing not reflected in

[1] The staff also has noted certain transactions in which leasing companies borrow non-recourse by collateralizing with lease receivables and/or the related leased assets and also sell a portion of the interest in the residual value of the leased assets to third party investors. These transactions may include the sale of the assets (subject to the leasing company's non-recourse borrowing and the lender's interest in the lease receivables and related leased assets) to the investor group, with the retention by the leasing company of a portion of the residual interest in the leased assets. The staff believes transactions in which the leasing company retains a future benefit in the leased assets and is not relieved of its (non-recourse) debt obligation, do not alter the leasing company's status with respect to either the end user of the assets (lessee) or the lender under the non-recourse borrowing and should not result in the recognition of a sale of the lease receivables or the offsetting of the lease receivables and non-recourse debt.

[2] Special provisions apply, however, if the sale or assignment is between related parties or with recourse.

[3] The term "sale" is generally used to refer to a contract or agreement by which property is transferred from a seller to a buyer in exchange for cash or a promise to pay a fixed price. "Assignment" is generally used to describe transfers of interests or rights. The legal determination of when a particular transaction represents a "sale" or an "assignment" is a matter of individual state law.

[4] In addition, the staff does not believe that non-recourse borrowing arrangements (which may be structured as sales with repurchase options) involving operating leases and/or the underlying leased assets should result in the recognition of a sale of the leased assets. Therefore, registrants involved in these transactions should continue to reflect the assets under lease on their balance sheets and should also record the resultant non-recourse debt.

[5] Paragraph 7 of Accounting Principles Board (APB) Opinion No. 10 indicates that "it is a general principle of accounting that the offsetting of assets and liabilities in the balance sheet is improper except where a right of setoff exists." Topic 11–D of the staff accounting bulletin series also indicates that "even when items can be directly associated it is not appropriate to offset assets and liabilities without the benefit of an existing legal right." The concept of legal right of offset embodied in Topic 11–D refers to the existence of a right between two parties, owing ascertainable amounts to each other to set off their respective debts by way of mutual deduction so that in any action brought for the larger debt, only the remainder after the deduction may be recovered. The debts must, therefore, be to and from the same parties acting on their own behalf. It should be noted that "right of setoff" as embodied in APB Opinion No. 10 and the concept of legal right of offset in Topic 11–D are intended to be similar in meaning.

[6] Paragraph 21 of this Technical Bulletin indicates that "offsetting the lease receivable with non-recourse debt is appropriate only in those circumstances in which a legal right of offset exists or when, at the inception of the lease, the lease meets all the characteristics of paragraph 42 of Statement 13 and is appropriately classified as a leveraged lease."

the balance sheet) of the different accounting treatment being followed.

[FR Doc. 87-13254 Filed 6-9-87; 8:45am]

BILLING CODE 8010-01-M

17 CFR Parts 229, 239, and 240

[Rel. Nos. 33-6715; 34-24514; 35-24397; IC-15753; File No. S7-29-86]

Proxy Rules; Conformation to Comprehensive Proxy Revisions, Provision for Modified or Superseded Documents

AGENCY: Securities and Exchange Commission.

ACTION: Final rules.

SUMMARY: The Securities and Exchange Commission ("Commission") today announced the adoption of amendments to its proxy rules and certain other rules. The amendments will conform further the proxy disclosure for mergers and similar transactions to that required for registration of securities in certain business combinations and will clarify the timing requirements for such transactions where incorporation by reference is used. The Commission also is adopting a rule concerning modified or susperseded statements in documents incorporated by reference into a proxy statement.

DATES: Effective Date: These amendments are effective July 10, 1987, for proxy statements filed on or after that date.

Compliance Date: Registrants are permitted, however, to comply with the amendments immediately upon publication of this Release in the **Federal Register.** Such compliance must be with the amended rules as a whole.

FOR FURTHER INFORMATION CONTACT: Prior to the effective date, Caroline W. Dixon or Barbara J. Green, (202) 272-2589, Office of Disclosure Policy, Division of Corporation Finance, Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549. After the effective date, contact Cecilia D. Blye, (202) 272-2573, Office of Chief Counsel, Division of Corporation Finance.

SUPPLEMENTARY INFORMATION: The Commission today announced the adoption of revisions to the proxy and information statement rules [1] under the Securities Exchange Act of 1934 ("Exchange Act").[2] The Commission is adopting revisions to Regulation 14A,[3] including Schedule 14A.[4] In addition, the Commission is adopting a new rule, Rule 14a-14.[5] which is part of Regulation 14A. Finally, corresponding amendments have been adopted to Forms S-4 [6] and F-4 [7] and to Item 304 of Regulation S-K.[8]

I. Discussion

A. Conforming Certain Disclosure Under Schedule 14A to Form S-4

The Commission is adopting as proposed [9] amendments to Item 14 of Schedule 14A, Mergers, Consolidations, Acquisitions and Similar Matters, to conform the company-specific information requirements for Item 14 with those of Form S-4, the registration form for certain business combination transactions. As a result of this amendment, Item 14(b)(3), Information with Respect to Registrants Other than S-2 or S-3 Registrants, subparagraph (i) is amended to require registrants to furnish all the information required by Item 101, Description of Business,[10] Item 102, Description of Property,[11] and Item 103, Legal Proceedings,[12] of Regulation S-K.

B. Description of Securities

Other Item 14 requirements for transaction information were conformed to the requirements of Form S-4 in the companion adopting release that accompanied the release proposing the changes now being adopted in this proposal.[13] As noted in that release, if the transaction involves the issuance of securities exempt from registration, information concerning the new class or series of securities can be material to the transaction. In the proposing release, the Commission sought comment as to whether there should be a specific requirement to include in a proxy or information statement all of the information that would be required by Item 202 of Regulation S-K [14] if securities were being registered and, if so, whether such a requirement should apply to all issuances of securities exempt from registration.

The Commission is amending Item 14 specifically to require the information called for by Item 202 for any securities that are exempt from registration if the security holders whose proxies are being solicited will be receiving the new securities.[15] If, however, a registrant solicits proxies from its security holders to authorize a transaction in which its securities are being issued to others, somewhat less extensive information concerning the new securities would be necessary. Such disclosure is currently required by Item 14(a)(3)(iii). Item 14(a)(3) requires a summary of the material features of the proposed transaction; subparagraph (iii) calls for an "explanation of any material differences in the rights of security holders of the registrant as a result of this transaction."

C. New Rule 14a-14, Modified or Superseded Documents

The Commission is adopting as proposed a new rule similar to Rule 412 under the Securities Act of 1933.[16] The rule governs the treatment of a statement in a document incorporated by reference into a proxy statement which is subsequently modified or superseded by a statement in a later document also incorporated by reference.

The rule provides that, for purposes of the proxy statement, a statement in a document incorporated by reference is deemed to be modified or superseded by a statement in the proxy statement or in any other subsequently filed document(s) incorporated by reference. The rule also provides (1) that the making of a modifying or superseding statement is not deemed an admission that the first statement was false or misleading and (2) that the prior form of any statement so modified or superseded is not deemed to constitute a part of the proxy statement.

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[1] 17 CFR 240.14a-1 through 240.14c 101.

[2] 15 U.S.C. 78a-78kk (1982).

[3] 17 CFR 240.14a-1 through 240.14b-1.

[4] 17 CFR 240.14a-101.

[5] 17 CFR 240.14a-14.

[6] 17 CFR 239.25.

[7] 17 CFR 239.34.

[8] 17 CFR 229.304. In addition, a reference to an obsolete form is being deleted from Item 512 of Regulation S-K (17 CFR 229.512).

[9] Release No. 33-6675 (November 20, 1986) [51 FR 42073]. The two comment letters that were received are available for public inspection and copying at the Commission's Public Reference Room [File No. S7-29-86].

[10] 17 CFR 229.101.

[11] 17 CFR 229.102.

[12] 17 CFR 229.103.

[13] Release No. 33-6676 (November 20, 1986) [51 FR 42048].

[14] 17 CFR 229.202, Description of Registrant's Securities.

[15] This information may be incorporated by reference if the issuer of the securities is eligible to use Form S-3 and information about the issuer is incorporated by reference into the proxy or information statement pursuant to the specific provisions for Form S-3 companies. Related technical changes are being made to Forms S-4 and F-4.

[16] 17 CFR 230.412.

D. Other Amendments [17]

1. Changes in and Disagreements with Accountants

The Commission also is adopting proposed amendments to clarify a potential ambiguity between Item 304 of Regular S-K [18] and Item 14 of Schedule 14A with regard to the required disclosure concerning changes in and disagreements with accountants for non-reporting companies being acquired by the registrant. The potential ambiguity existed because Instruction 3 to Item 304 provided that the information required by Item 304 need not be provided for non-reporting companies being acquired by the registrant, whereas Item 14 specified that Item 304 information was required for such persons. Item 14 controls with respect to disclosure of the financial statement effect of subsequently accounting for similar transactions in a manner different from that preferred by the former accountant as required by paragraph (b) of Item 304. The Commission has specified in the amendments that it is not necessary to provide the information called for by paragraph (a) of Item 304 with respect to such acquired company.[19]

2. Filing Requirements

Rule 14a-6 [20] has been revised to delete language in paragraph (j) stating that a transaction involving an application or declaration under the Public Utility Holding Company Act of 1935 ("PUHCA") [21] is exempt from the proxy solicitation filing fee, because the language is redundant. Rule 14a-2 [22] provides that Rules 14a-3 [23] to 14a-12 [24] do not apply to "any solicitation which is subject to Rule 62 under the Public Utility Holding Company Act." [25] It also should be noted that, as a PUHCA Rule 62 transaction is exempt from the Exchange Act proxy rules, an application or declaration under PUHCA also would be exempt from the filing fee requirements of Rule 14a-6(j).[26]

3. Mailing Where Incorporation by Reference is Used

Note D.3 to Schedule 14A requires that proxy material must be sent 20 business days prior to specified dates if documents or portions of documents are incorporated by reference as permitted by Items 13, Financial and Other Information, and 14, Mergers, Consolidations, Acquisitions and Similar Matters. As amended, the note clarifies that, where no meeting is held, the date by which material must be sent is 20 business days prior to the date the votes, consents or authorizations may be used to effect corporate action. The amended language conforms to language used elsewhere in the proxy rules to address similar circumstances.[27]

Similar revisions to instructions to Forms S-4 and F-4 have been made. Unlike revised Note D.3, these instructions retain the reference to the date the transaction is consummated because certain transactions involving the registration of securities pursuant to Forms S-4 or F-4 (such as a tender offer or short-form merger) need not involve the use of votes, consents or authorizations to effect corporate action.[28]

4. Clarifying Amendments as to Compensation Plans

The Commission has made technical revisions to Item 10 of Schedule 14A to clarify that, with respect to the exercise or realization of options or stock appreciation rights held in tandem with options, information concerning the net value of securities (market value less any exercise price) or cash realized need not be provided for employees as a group. In addition, language has been added to clarify that (1) references to directors who are not executive officers in Item 10(a)(2)(iii), Item 10(a)(3)(iii) and Item 10(b)(2)(ii)(C) refer to those currently in office and that these items also require disclosure with regard to all officers who are not executive officers; (2) Item 10(a) covers both the plan being voted upon and, in the case of Item 10(a)(3), all compensation plans currently in effect or in effect during the last three years; and (3) Item 10(b)(2) (options, warrants or rights submitted for security holders' action) applies to both individual grants of options, warrants or rights and to compensation plans that utilize options, warrants or rights.

5. Clarifying Instruction With Regard to Disclosure of Pro Forma Financial Information for Business Combinations

Among the Item 14 requirements for transaction information that were conformed to Form S-4 are items that call for material information required by Item 301 of Regulation S-K,[29] Selected Financial Data, with regard to the registrant or the other person on a pro forma basis, giving effect to the transaction, and pro forma and equivalent pro forma per share data for (1) book value, (2) cash dividends declared, and (3) income (loss) per share from continuing operations. These items and an accompanying instruction have been clarified in accordance with existing staff interpretations of Form S-4. The revisions make clear that, for a business combination accounted for as a purchase, the financial information called for by paragraphs (a)(6) and (a)(7) is to be provided for the most recent fiscal year and interim period. For a business combination accounted for as a pooling, the financial information is to be provided for the three most recent fiscal years and interim period, with the exception of the information with regard to book value which is to be provided for the most recent fiscal year and interim period.[30]

II. Cost-Benefit Analysis

To evaluate the benefits and costs associated with the amendments to Item 14 of Schedule 14A, Rule 14a-6, Item 304 of Regulation S-K, and Form S-4 and new Rule 14a-14, the Commission requested commentators to provide views and data as to the costs and benefits associated with these changes. No comments were received. As the Commission noted in the proposing release, however, the amendments will

[17] In addition to the amendments discussed below, minor technical revisions necessitated by the comprehensive proxy revisions or by technical clarifications also have been made. Specifically, references have been corrected in Instructions 3, 4 and 6 to Item 14, and in Items 13, 14, 18 and 19 of Form S-4. Finally, a reference to an obsolete form, Form S-14, has been removed from Item 512 of Regulation S-K (17 CFR 229.512).

[18] Changes in and Disagreements with Accountants.

[19] A parallel amendment has been made to Item 17 of Form S-4 to require only the Item 304(b) information in the same circumstances. In addition, Items 18 and 19 of Form F-4 have been amended to delete the requirement to provide the information called for by Item 9 of Schedule 14A, making Form F-4 consistent with Forms F-1-2-3. Corresponding changes have been made to reflect the necessary redesignations.

[20] 17 CFR 240.14a-6.

[21] 15 U.S.C. 79-79z-6.

[22] 17 CFR 240.14a-2.

[23] 17 CFR 240.14a-3.

[24] 17 CFR 240.14a-12.

[25] 17 CFR 250.62. PUHCA Rule 62(a) covers reorganizations subject to Commission approval and transactions that are the subject of an application or declaration filed with the Commission. Other public utility holding company solicitations are governed by PUHCA Rule 61, which provides that such solicitations are subject to Exchange Act section 14(a) (15 U.S.C. 78n(a)).

[26] 17 CFR 240. 14a-6(j).

[27] The changes conform the language to that used in Rules 14a-3(b)(13) (17 CFR 240.14a-3(b)(13)), 14a-13(a)(2) (17 CFR 240.14a-13(a)(2)) and 14c-2(b) (17 CFR 240.14c-2(b)).

[28] Questions have been raised as to the meaning of "the date the transaction is consummated" in the context of an exchange offer filing using incorporation by reference. The prospectus should be furnished at least 20 business days before the scheduled termination of the exchange offer.

[29] 17 CFR 229.301.

[30] Parallel amendments have been made to Forms S-4 and F-4.

either not have an effect or have a minimal effect on costs.

III. Final Regulatory Flexibility Analysis

This final regulatory flexibility analysis, which relates to amendments to the proxy rules and certain conforming amendments to other rules, has been prepared in accordance with 5 U.S.C. 604. The corresponding Initial Regulatory Flexibility Analysis is continued in the proposing release.

The Need for, and Objectives of New Rule 14a-14 and Amendments to the Proxy and Other Rules

The current revisions result from comprehensive revisions to the proxy and other rules undertaken to clarify, to provide certainty by codifying staff interpretation, and to simplify the proxy and other rules. The principal purpose of the proxy rules, to ensure that information is made available to security holders being asked to vote on or consent to corporate action, is furthered by such clarification, codification and simplification. Certain of these amendments clarify existing rules and eliminate potential ambiguities in required disclosure. The amendments also include Rule 14a-14 which facilitates a registrant's ability to update information included in a document that is incorporated by reference in a proxy statement without requiring any additional action by the registrant and without imposing any additional reporting, recordkeeping or compliance requirements.

Public Comment

No commentators responded to the Commission's request for comments on the Initial Regulatory Flexibility Analysis.

Significant Alternatives

Pursuant to section 604 of the Regulatory Flexibility Act, the following types of alternatives were considered:

(1) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities;

(2) The clarification, consolidation or simplification of compliance and reporting requirements under the rules for such small entities;

(3) The use of performance rather than design standards; and

(4) An exemption from coverage of the rules, or any part thereof, for small entities.

The Commission does not believe, however, that it would be consistent with the Commission's statutory mandate to protect investors, to establish different compliance or reporting requirements with respect to the amendments to Item 14 of Schedule 14A and to Item 304 of Regulation S-K that would take into account the resources available to small entities. The disclosure called for by the amendments would be useful to security holders of small entities as well as to security holders of large entities.

The clarifying amendments to Items 10 and 14 and to Note D.3 of Schedule 14A will provide needed clarification which will be beneficial to small entities as well as large entities; the Commission does not believe that further simplification for small entities is consistent with the Commission's statutory mandate. Nor does the Commission believe that use of performance rather than design standards is appropriate in the context of the revised rules given the Commission's statutory mandate. With regard to the amendments to Item 14 other than clarifying amendments, an alternative would have been to exempt small entities from these requirements. The Commission does not believe, however, that extending an exemption to or providing different compliance or reporting requirements for small entities for transactions requiring compliance with Item 14 of Schedule 14A that would not otherwise involve registration on Form S-4 would be warranted in light of the Commission's statutory mandate. The Commission also believes that it is appropriate to conform the requirements of Item 14 and Form S-4 as they involve substantially the same decision by security holders. Further, if a small entity files preliminary proxy material meeting the requirements of Item 14 and the filing of a Form S-4 is contemplated for the transaction, the requirements of Form S-4 must be satisfied. In addition, the information called for by Item 202 of Regulation S-K, Description of Registrant's Securities, should be provided in a transaction involving a business combination, notwithstanding that the issuance is exempt from registration, if security holders whose proxies are being solicited will be receiving the securities. Rule 14a-14 provides relief with regard to the updating of information that any other approach is unlikely to provide for small as well as large entities.

IV. Statutory Basis

The amendments to the proxy and information statement rules and to Items 304 and 512 of Regulation S-K, Form S-4, and Form F-4 are being adopted by the Commission pursuant to sections 6, 7, 10 and 19(a) of the Securities Act of 1963 and sections 14 and 23(a) of the Securities Exchange Act of 1934.

List of Subjects in 17 CFR Parts 229, 230 and 240

Reporting and recordkeeping requirements, Securities.

Text of Amendments

In accordance with the foregoing, Title 17, Chapter II of the Code of Federal Regulations is amended as follows:

PART 240—GENERAL RULES AND REGULATIONS, SECURITIES EXCHANGE ACT OF 1934

1. The authority citation for Part 240 continues to read in part as follows:

Authority: Sec. 23, 48 Stat. 901, as amended, 15 U.S.C. 78w. * * *

§ 240.14a-2 [Amended]

2. The section heading, introductory text, paragraph (a) introductory text, and (b) introductory text of § 240.14a-2 are amended by removing the references to "14a-13" and replacing them with references to "14a-14."

3. The introductory text of paragraph (j) of § 240.14a-6 is revised as follows:

§ 240.14a-6 Filing requirements.

* * * * *

(j) *Fees.* At the time of filing the preliminary proxy solicitation is material, the persons upon whose behalf the solicitation is made, other than companies registered under the Investment Company Act of 1940, shall pay to the Commission the following applicable fee: * * *

* * * * *

§ 240.14a-8 [Amended]

4. Section 240.14a-8 is amended by removing the word "issuer's" and replacing it with the word "registrant's" in paragraph (c)(1).

§ 240.14a-11 [Amended]

5. Section 240.14a-11 is amended by removing the word "issuer" and replacing it with the word "registrant" in paragraph (b)(5).

6. By adding § 240.14a-14 to read as follows:

§ 240.14a-14 Modified or superseded documents.

(a) Any statement contained in a document incorporated or deemed to be incorporated by reference shall be deemed to be modified or superseded, for purposes of the proxy statement, to the extent that a statement contained in the proxy statement or in any other subsequently filed document that also is or is deemed to be incorporated by

reference modifies or replaces such statement.

(b) The modifying or superseding statement may, but need not, state it has modified or superseded a prior statement or include any other information set forth in the document that is not so modified or superseded. The making of a modifying or superseding statement shall not be deemed an admission that the modified or superseded statement, when made, constituted an untrue statement of a material fact, an omission to state a material fact necessary to make a statement not misleading, or the employment of a manipulative, deceptive, or fraudulent device, contrivance, scheme, transaction, act, practice, course of business or artifice to defraud, as those terms are used in the Securities Act of 1933, the Securities Exchange Act of 1934 ("the Act"), the Public Utility Holding Company Act of 1935, the Investment Company Act of 1940, or the rules and regulations thereunder.

(c) Any statement so modified shall not be deemed in its unmodified form to constitute part of the proxy statement for purposes of the Act. Any statement so superseded shall not be deemed to constitute a part of the proxy statement for purposes of the Act.

7. Section 240.14a-101 is amended by removing the word "issuer" and replacing it with the word "registrant" in two places in Item 15(c) and by revising Note D.3, Item 10 introductory text, Item 10(a)(1) first phrase, (a)(2), (a)(3), (b)(2) introductory text, (b)(2)(ii) and (b)(2)(ii)(C). Item 14 is amended by revising the introductory text to Item 14(b)(1)(iii), Item 14(b)(3)(i) (A), (B), and (C) and (ii)(C), by adding Item 14(a)(3)(vi), Item 14(b)(1)(iii)(C) and Item 14(b)(3)(ii) (D) and (E) and by revising Instruction 3 introductory text and Instruction 4. Also, in Item 14, paragraph (a)(5) is revised, a new paragraph (a)(6) is added and current paragraphs (a)(6)–(a)(12) are renumbered sequentially. The "instructions to paragraph (a)(6)" is retitled "instructions to paragraphs (a)(6) and (a)(7)" and is amended by revising the first sentence and adding two new sentences following the first sentence. These instructions follow new paragraph (a)(7). The "instructions to paragraph (a)(7)" is retitled "instructions to paragraph (a)(8)." Instruction 6 to Item 14 is amended by adding a reference to paragraph (a)(6) following the reference to paragraph (a)(5).

§ 240.14a-101 Schedule 14A. Information required in proxy statement.

Notes—* * *

D. * * *

3. If a document or portion of a document other than an annual report sent to security holders pursuant to the requirements of Rule 14a-3 (§ 240.14a-3 of this chapter) with respect to the same meeting or solicitation of consents or authorizations as that to which the proxy statement relates is incorporated by reference in the manner permitted by Item 13(b) or 14(b) of this schedule, the proxy statement must be sent to security holders no later than 20 business days prior to the date on which the meeting of such security holders is held or, if no meeting is held, at least 20 business days prior to the date the votes, consents or authorizations may be used to effect the corporate action.

* * * * *

Item 10. Compensation Plans. If action is to be taken with respect to any plan pursuant to which cash or non-cash compensation may be paid, furnish the following information:

(a) *All Plans.* (1) Describe briefly the material features of the plan being acted upon, identify each class of persons * * *

(2) State the benefits or amounts which will be received by or allocated to each of the following under the plan being acted upon, if such benefits or amounts are determinable: (i) Each person (stating name and position) specified in paragraph (a)(1)(i) of Item 402 of Regulation S-K (§ 229.402 of this chapter); (ii) all current executive officers as a group; (iii) all other current officers and directors who are not executive officers as a group; and (iv) all employees as a group. If such benefits or amounts are not determinable, state the benefits or amounts which would have been received by or allocated to each of the following for the last fiscal year if the plan had been in effect, if such benefits or amounts may be determined: (i) Each person (stating name and position) specified in paragraph (a)(1)(i) of Item 402 of Regulation S-K (§ 229.402 of this chapter); (ii) all current executive officers as a group; (iii) all other current officers and directors who are not executive officers as a group; and (iv) all employees as a group.

(3) Furnish the information called for by Item 402(b) of Regulation S-K (§ 229.402 of this chapter) with respect to all compensation plans now in effect or in effect during the last three years except that information called for in paragraphs (b)(1) (vi) and (vii) and (b)(4) of Item 402(b) of Regulation S-K (§ 229.402 of this chapter) should be furnished with respect to the last three fiscal years for the following: (i) Each person (stating name and position) specified in Item 402(a)(1)(i) of Regulation S-K (§ 229.402 of this chapter); (ii) all current executive officers as a group; (iii) all other current officers and directors who are not executive officers as a group, if such persons may participate in the plan; and (iv) all employees as a group, if such persons may participate in the plan. The information called for by paragraph (b)(4)(ii) of Item 402 of Regulation S-K (§ 229.402 of this chapter) need not be provided for all employees as a group. The information required by this paragraph (a)(3) is in lieu of the information otherwise called for by Item 402(b) of Regulation S-K (§ 229.402 of this chapter) in connection with the disclosure required by Item 8 of this schedule.

* * * * *

(b) * * *

(2) With respect to any specific grant of or any plan containing options, warrants or rights submitted for security holder action, * * * (ii) state separately the amount of such options received or to be received by the following persons if such benefits or amounts are determinable: * * * (C) all other current officers and directors who are not executive officers as a group; * * *

* * * * *

Item 14. Mergers, Consolidations, Acquisitions and Similar Matters.

* * * * *

(a) *Information about the transaction.*

* * * * *

(3) * * *

(vi) The information required by Item 202 of Regulation S-K (§ 229.202 of this chapter), description of registrant's securities, for any securities that are exempt from registration and are being issued in connection with the transaction if the security holders entitled to vote or give an authorization or consent with regard to the transaction will receive such securities, unless: (i) The issuer of the securities would meet the requirements for use of Form S-3 and elects to furnish information in accordance with the provisions of paragraph (b)(1), (ii) capital stock is to be issued and (iii) securities of the same class are registered under Section 12 of the Exchange Act and either (a) are listed for trading or admitted to unlisted trading privileges on a national securities exchange; or (b) are securities for which bid and offer quotations are reported in an automated quotations system operated by a national securities association;

* * * * *

(5) The information required by Item 301 of Regulation S-K (§ 229.301 of this chapter), selected financial data, for the registrant and the other person.

(6) If material, the information required by Item 301 of Regulation S-K for the registrant or the other person on a pro forma basis, giving effect to the transaction.

* * * * *

Instruction to paragraphs (a)(6) and (a)(7)

For a business combination accounted for as a purchase, the financial information required by paragraphs (a)(6) and (a)(7) shall be presented only for the most recent fiscal year and interim period. For a business combination accounted for as a pooling, the financial information required by paragraphs (a)(6) and (a)(7) (except for information with regard to book value) shall be presented for the most recent three fiscal years and interim period. For a business combination accounted for as a pooling, information with regard to book value shall be presented as of the end of the most recent fiscal year and interim period. * * *

* * * * *

(b) *Information about the registrant and the other person.*

* * * * *

(1) *Information with respect to S–3 registrants.*

* * * * *

(iii) Incorporate by reference into the proxy statement the documents listed in paragraphs (A), (B) and, if applicable, (C) below:

* * * * *

(C) If capital stock is to be issued to security holders entitled to vote or give an authorization or consent and securities of the same class are registered under Section 12 of the Exchange Act and: (i) are listed for trading or admitted to unlisted trading privileges on a national securities exchange; or (ii) are securities for which bid and offer quotations are reported on an automated quotations system operated by a national securities association, the description of such class of securities which is contained in a registration statement filed under the Exchange Act, including any amendment or reports filed for the purpose of updating such description.

* * * * *

(3) *Information with respect to registrants other than S–2 or S–3 registrants.*

(i) * * *

(A) Information required by Item 101 of Regulation S–K (§ 229.101 of this chapter), description of business.

(B) Information required by Item 102 of Regulation S–K (§ 229.102 of this chapter), description of property.

(C) Information required by Item 103 of Regulation S–K (§ 229.103 of this chapter), legal proceedings.

* * * * *

(ii) * * *

* * * * *

(C) A brief description of the business done by the company which indicates the general nature and scope of the business;

(D) The information required by paragraphs (b)(3)(i)(D) and (F)–(H) of this Item and the information required by Item 304(b) of Regulation S–K (§ 229.304 of this chapter).

(E) Schedules required by Rules 12–15, 28 and 29 of Regulation S–X.

(c) *Additional method of incorporation by reference.* * * *

* * * * *

Instructions to Item 14

* * * * *

3. If the registrant or any of its securities or assets is to be acquired by the other person, the information regarding the other person that is required by this Item, other than information required by paragraphs (a)(1)–(3) and (a)(9)–(11) of this Item, need be provided only to the extent that: * * *

4. If the plan being voted on involves only the registrant and one or more of its totally held subsidiaries and does not involve a liquidation of the registrant or a spin-off, the information required by this Item, other than information required by paragraphs (a)(1)–(4) and (a)(9)–(12) of this Item, may be omitted.

* * * * *

PART 239—FORMS PRESCRIBED UNDER THE SECURITIES ACT OF 1933

8. The authority citation for Part 239 continues to read, in part, as follows:

Authority: The Securities Act of 1933, 15 U.S.C. 77a, *et seq.*, * * *

9. Form S–4 (§ 239.25) is amended by revising the first sentence of Instruction A.2. In Item 3, paragraph (d) is divided into paragraphs (d) and (e) and subsequent paragraphs are relettered sequentially; the "instruction to paragraph (e)" is retitled "instruction to paragraphs (e) and (f)" and amended by revising the first sentence and adding two new sentences following the first sentence. This instruction follows paragraph (f). Item 4(a)(3) introductory text and item 4(a)(3)(i) are revised. In Item 13(a)(3)(vi) and Item 14(i), references to Item 304 of Regulation S–K are changed from "disagreements with accountants on accounting and financial disclosure" to "changes in and disagreements with accountants on accounting and financial disclosure." Form S–4 also is amended by revising Item 17(b)(6), by, in Item 18(b), removing the reference to paragraph "(a)(4)(ii)" and replacing it with a reference to paragraph "(a)(5)(ii)." The section also is amended by, in Item 19(b), removing the reference to paragraph "(a)(6)," removing the reference to paragraph "(a)(8)" and replacing it with a reference to paragraph "(a)(7);" and, in Item 19(c), removing the reference to paragraph "(a)(18)" and replacing it with a reference to paragraph "(a)(7)."

The text of Form S–4 does not appear in Code of Federal Regulations.

§ 239.25 Form S–4, for the registration of securities issued in business combination transactions.

* * * * *

Form S–4

* * * * *

General Instructions

A. Rule as to Use of Form S–4.

1. * * *

2. If the registrant meets the requirements of and elects to comply with the provisions in any item of this Form of Form F–4 (§ 239.34 of this chapter) that provides for incorporation by reference of information about the registrant or the company being acquired, the prospectus must be sent to the security holders no later than 20 business days prior to the date on which the meeting of such security holders is held or, if no meeting is held, at least 20 business days prior to either (1) the date the votes, consents or authorizations may be used to effect the corporate action or, (2) if votes, consents or authorizations are not used, the date the transaction is consummated. * * *

* * * * *

Item 3. Risk Factors, Ratio of Earnings to Fixed Charges and Other Information. * * *

* * * * *

(d) The information required by Item 301 of Regulation S–K (§ 229.301 of this chapter) (selected financial data) for the registrant and the company being acquired. To the extent the information is required to be presented in the prospectus pursuant to Items 12, 14, 16 or 17, it need not be repeated pursuant to this Item.

(e) If material, the information required by Item 301 of Regulation S–K for the registrant on a pro forma basis, giving effect to the transaction. To the extent the information is required to be presented in the prospectus pursuant to Items 12 or 14, it need not be repeated pursuant to this Item.

* * * * *

Instruction to paragraphs (e) and (f)

For a business combination accounted for as a purchase, the financial information required by paragraphs (e) and (f) shall be presented only for the most recent fiscal year and interim period. For a business combination accounted for as a pooling, the financial information required by paragraphs (e) and (f) (except for information with regard to book value) shall be presented for the most recent three fiscal years and interim period. For a business combination accounted for as a pooling, information with regard to book value shall be presented as of the end of the most recent fiscal year and interim period. * * *

* * * * *

Item 4. Terms of the Transaction.

(a) * * *

(2) * * *

(3) The information required by Item 202 of Regulation S–K (§ 229.202 of this chapter), description of registrant's securities, unless: (i) The registrant would meet the requirements for use of Form S–3 and elects to furnish information pursuant to Item 10, * * *

* * * * *

Item 17. Information With Respect to Companies Other than S–2 or S–3 Companies.

* * * * *

(b) * * *

(6) Item 304(b) of Regulation S–K (§ 229.304 of this chapter), changes in and disagreements with accountants on accounting and financial disclosure.

* * * * *

10. Form F–4 (§ 239.34) is amended by, revising the first sentence of General Instruction A.2, in Item 3, dividing paragraph (d) into paragraphs (d) and (e) and relettering subsequent paragraphs sequentially. The "instructions" to paragraph (e) is retitled "instructions to paragraphs (e) and (f)" and is amended by revising the first sentence in paragraph 1 and adding two new sentences following the first sentence in paragraph 1. These instructions follow paragraph (f). Form F–4 also is amended by revising Item 4 paragraph (a)(3) introductory text and paragraph (a)(3)(i), in Item 18, removing

paragraph (a)(6), renumbering subsequent paragraphs and adding new paragraph (a)(7); in Item 18(b), removing the reference to paragraph (a)(4)(ii) and replacing it with a reference to (a)(5)(ii); in Item 19, removing paragraph (a)(6) and renumbering subsequent paragraphs; in Item 19(b), removing the reference to paragraph (a)(6) and removing the reference to paragraph (a)(8) and replacing it with a reference to paragraph (a)(7); and, in Item 19(c), removing a reference to paragraph (a)(8) and replacing it with a reference to paragraph (a)(7).

The text of Form F-4 does not appear in the Code of Federal Regulations. § *239.34 Form F-4, for registration of securities of certain foreign private issuers issued in certain business combination transactions.*

* * * * *

Form F-4

General Instructions

A. Rule as to Use of Form F-4.

1. * * *

2. If the registrant meets the requirements of and elects to comply with the provisions in any item of this Form or Form S-4 (§ 239.25) that provides for incorporation by reference of information about the registrant or the company being acquired, the prospectus must be sent to the security holders no later than 20 business days prior to the date on which the meeting of such security holders is held or, if no meeting is held, the earlier of 20 business days prior to either (1) the date the votes, consents or authorizations may be used to effect the corporate action or (2) if votes, consents or authorizations are not used, the date the transaction is consummated. * * *

* * * * *

Item 3. Risk Factors, Ratio of Earnings to Fixed Charges and Other Information.

* * * * *

(d) The information required by Item 8 of Form 20-F (selected financial data) for the registrant and the company being acquired. If the information is required to be presented in the prospectus pursuant to Items 12, 14, 16 or 17, it need not be presented pursuant to this Item.

(e) If material, the information required by Item 8 of Form 20-F for the registrant on a pro forma basis, giving effect to the transaction. If the information is required to be presented in the prospectus pursuant to Items 12 or 14, it need not be presented pursuant to this Item.

* * * * *

Instructions to paragraphs (e) and (f)

1. For a business combination accounted for as a purchase, the financial information required by paragraphs (e) and (f) shall be presented only for the most recent fiscal year and interim period. For a business combination accounted for as a pooling, the financial information required by paragraphs (e) and (f) (except for information with regard to book value) shall be presented for the most recent three fiscal years and interim period. For a business combination accounted for as a pooling, information with regard to book value shall be presented as of the end of the most recent fiscal year and interim period. * * *

2. * * *

* * * * *

Item 4. Terms of the Transaction.

(a) * * *

(3) The information required by Item 202 of Regulation S-K (§ 229.202 of this chapter), description of registrant's securities, unless: (i) The registrant would meet the requirements for use of Form F-3 and elects to furnish information pursuant to Item 10,

(ii) * * *

* * * * *

Item 18. Information if Proxies, Consents or Authorizations Are To Be Solicited.

(a) * * *

Instruction * * *

(6) The information required by Item 21 of Schedule 14A, vote required for approval;

(7) With respect to each person who will serve as a director or an executive officer of the surviving or acquiring company, the information required by:

(i) Item 10 of Form 20-F, directors and officers of registrant;

(ii) Items 11 and 12 of Form 20-F, remuneration and options; and

(iii) Item 13 of Form 20-F, interest of management in certain transactions.

* * * * *

PART 229—STANDARD INSTRUCTIONS FOR FILING FORMS UNDER THE SECURITIES ACT OF 1933 AND SECURITIES EXCHANGE ACT OF 1934 AND ENERGY POLICY CONSERVATION ACT OF 1975—REGULATION S-K

11. The authority citation for Part 229 continues to read, in part, as follows:

Authority: Secs. 6, 7, 8, 10, 19(a), 48 Stat. 78, 79, 81, 85; secs. 12, 13, 14, 15(d), 23(a), 48 Stat. 892, 894, 901; secs. 205, 209, 48 Stat. 906, 908; sec. 203(a), 49 Stat. 704; secs. 1, 3, 8, 49 Stat. 1375, 1377, 1379; sec. 301, 54 Stat. 857; secs. 8, 202, 68 Stat. 685, 686; secs. 3, 4, 5, 6, 78 Stat. 565-568, 569, 570-574; sec. 1, 79 Stat. 1051; secs. 1, 2, 3, 82 Stat. 454, 455; secs. 1, 2, 3-5, 28 (c), 84 Stat. 1435, 1497; sec. 105(b), 68 Stat. 1503; secs. 8, 9, 10, 11, 18, 69 Stat. 117, 118, 119, 155; 15 U.S.C. 77f, 77g, 77h, 77j, 77s(a), 78l, 78m, 78n, 78l(d), 78w(a). * * *

12. Instruction 3 of § 229.304 is revised as follows.

§ 229.304 (Item 304) Changes in and disagreements with accountants on accounting and financial disclosure.

* * * * *

Instructions to Item 304:

* * * * *

3. The information required by Item 304(a) need not be provided for a company being acquired by the registrant that is not subject to the reporting requirements of either section 13(a) or 15(d) of the Exchange Act, or, because of section 12(i) of the Exchange Act, has not furnished an annual report to security holders pursuant to Rule 14a-3 or Rule 14c-3 for its latest fiscal year.

§ 229.512 [Amended]

13. Paragraph (h), heading and introductory text, of § 229.512 is amended by removing the references to "S-14."

By the Commission.

Jonathan G. Katz,

Secretary.

May 27, 1987.

[FR Doc. 87-12573 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

20 CFR Part 416

[Reg. No. 16]

Supplemental Security Income for the Aged, Blind, and Disabled; Residence and Citizenship

AGENCY: Social Security Administration, HHS.

ACTION: Final rules.

SUMMARY: These final rules implement the order of the United States Court of Appeals for the Second Circuit in the case of *Berger* v. *Heckler*, 771 F.2d 1556 (1985). The court order substantially affirms the order of the District Court in *Berger* v. *Schweiker*, No. CV-76-1420 (E.D.N.Y. July 31, 1984) which sets out criteria for determining whether an alien is permanently residing in the United States (U.S.) under color of law and lists specific categories of aliens who meet the criteria and thus may be eligible for Supplemental Security Income (SSI) benefits. These final regulations provide that aliens residing in the U.S. with the knowledge and permission of the Immigration and Naturalization Service (INS) and whose departure INS does not contemplate enforcing are permanently residing in the U.S. under color of law. The rules set out specific categories of aliens who meet these criteria along with the most common documents INS provides to aliens in these categories. The rules were published as a Notice of Proposed Rulemaking in the **Federal Register** on March 19, 1986 (51 FR 9462) with a 60-day comment period. A number of comments were received and are discussed under the heading titled *Discussion of Comments.*

EFFECTIVE DATE: These rules are effective June 10, 1987.

FOR FURTHER INFORMATION CONTACT: Dave Smith, Office of Regulations, Social Security Administration, 6401 Security Boulevard, Baltimore,

Maryland 21235, Telephone 301-594-7460.

SUPPLEMENTARY INFORMATION: Section 1614(a)(1)(B) of the Social Security Act requires that an individual must be a citizen, or an alien either lawfully admitted for permanent residence or permanently residing in the U.S. under color of law, to be eligible for SSI benefits. The current regulations at 20 CFR 416.1618 do not define "permanently residing in the U.S. under color of law" but rather set out what evidence an individual must provide to prove he or she is permanently residing in the U.S. under color of law. Our policies regarding this requirement under the SSI program were the subject of litigation in *Berger* v. *Secretary*, No. 76C 1420 (E.D.N.Y. June 13, 1978). Under the final judgment entered June 13, 1978, aliens who were residing in the U.S. with the knowledge and permission of INS and whose departure INS did not contemplate enforcing were permanently residing in the U.S. under color of law and thus were potentially eligible for SSI benefits. The final judgment contained language to that effect.

After further litigation, the District Court in *Berger* v. *Schweiker*, CV-76-1420 (E.D.N.Y. July 31, 1984) set out more specific criteria for determining if an alien is permanently residing in the U.S. under color of law. The court order again provided that aliens residing in the U.S. with the knowledge and permission of INS and whose departure INS does not contemplate enforcing are aliens permanently residing in the U.S. under color of law for SSI purposes. Under the terms of the court order, INS will not be considered as contemplating enforcing an alien's departure if it is the policy or practice of INS not to enforce the departure of aliens in the same category or if from all the facts and circumstances in a particular case it appears that INS is permitting the alien to reside in the U.S. indefinitely. The court order also listed certain categories of aliens as examples of categories which meet the PRUCOL requirement. The court order required that our regulations and operating instructions contain its criteria for color of law determinations and the specified categories of aliens who are considered as PRUCOL. On appeal the United States Court of Appeals for the Second Circuit in *Berger* v. *Heckler*, 771 F. 2d 1556 (1985), affirmed the district court order, except that it did not require the Secretary to use the exact language specified by the district court. However, we have decided to adopt much of the language provided by the district court as it gives the most specific guidance on how the court's holding is to be interpreted. Because under the courts' orders more aliens will meet the definition of color of law than under our current regulations, more aliens may now be eligible for SSI benefits if they meet all other requirements for eligibility.

These final regulations apply only to the SSI program under title XVI of the Social Security Act. The regulations do not apply to permanently residing in the U.S. under color of law determinations under other Federal statutes. The regulations do not apply to applicants for an Immigration and Naturalization status other than applicants specifically listed in *Berger* v. *Heckler*, 771 F. 2d 1556 (1985). In addition, the regulations do not apply to nonimmigrants as listed in section 1101(a)(15) of the Immigration and Nationality Act, 8 U.S.C. 1101(a)(15).

Provisions of the Regulations

These final regulations amend § 416.1618 to provide that aliens residing in the U.S. with the knowledge and permission of INS and whose departure INS does not contemplate enforcing are permanently residing in the U.S. under color of law. The final regulations list the categories of aliens specified in the *Berger* district court order as aliens permanently residing in the U.S. under color of law (PRUCOL). The court order requires us to determine PRUCOL based on whether INS contemplates enforcing the alien's departure for aliens in some of these categories. Other categories, specified by the court, do not require us to consider whether INS contemplates enforcing departure since, by their nature, these categories imply that INS does not contemplate enforcing the alien's departure. Also listed are the most common documents INS provides to aliens in all of these categories.

The regulations require the alien to provide proof that he or she is in one of the categories by presenting one of the documents listed or any other information he or she has. We will contact INS in every case to verify the alien's current status and, in the required cases, to obtain information from INS as to whether an alien is PRUCOL based on whether INS contemplates enforcing the alien's departure.

Under the regulations, if an alien gives us proof that he or she is in a category that does not require us to consider whether INS contemplates enforcing departure, we will begin benefit payments if all other eligibility factors are met. We will then verify the alien's status with INS.

If an alien gives us proof that he or she is in a category that requires us to find out whether INS contemplates enforcing the alien's departure, the regulations provide as follows:

If an alien has a *document currently valid for either an indefinite period of time or for at least 1 year*, we will assume that INS does not contemplate enforcing the alien's departure. We will apply the same assumption for an alien who shows us a letter from INS that specifically indicates that INS is allowing the alien to remain in the U.S. for a specified period of time because of conditions in the alien's home country. If all other factors of eligibility are met, we will begin payment immediately. If, based on the information we receive from our contact with INS, we learn that INS does not contemplate enforcing the alien's departure, benefits will continue. However, if we learn that INS does contemplate enforcing the departure of the individual, we will suspend benefits. For aliens with documents valid for an indefinite period, INS verification of that document as currently valid is sufficient proof that INS does not contemplate enforcing the alien's departure. For aliens with documents valid for at least 1 year, we need INS verification of the document as currently valid as well as other INS information as to whether INS contemplates enforcing the alien's departure.

With the exception of aliens allowed to stay in the U.S. because of conditions in the alien's home country, if an individual presents a *document valid for less than 1 year or a document with no expiration date or has no document*, we will not pay benefits until we get information from INS as to whether INS contemplates enforcing the alien's departure. If INS does not contemplate enforcing the alien's departure, we will pay benefits if all other eligibility factors are met.

These policies were developed based on our experience in processing such claims and on information obtained from INS. Our experience with INS practices indicates that INS generally grants 1-year statuses for humanitarian reasons and usually continues to renew these statuses. In addition, we have been advised by INS that it continuously renews the status of aliens for whom a special determination was made to allow them to remain in the U.S. for a specified period due to conditions in their home country. INS, therefore, does not contemplate enforcing departure of individuals with these statuses. By contrast, it has been our experience that INS generally does not renew statuses that are valid for less than a year. These policies will enable us to pay benefits as promptly as possible to those individuals whose departure INS most likely does not contemplate enforcing.

In addition, we are deleting from § 416.1618 the provision in paragraph (a)(3) that provides for certain aliens to be considered as PRUCOL as a result of a March 10, 1977 court order. That court

order in *Silva* v. *Levi*, No. 76 C 4268 (N.D.Ill. 1977), enjoined INS from deporting certain aliens and required INS to notify those aliens that they were authorized to remain in the U.S. for an indefinite period of time. Since the aliens could reside in the U.S. indefinitely, we considered them to be PRUCOL for SSI purposes. The *Silva* injunction was dissolved as of November 1, 1981. Since *Silva* aliens who did not have their alien status adjusted during the pendency of the injunction are no longer protected from deportation they are no longer being allowed to reside in the U.S. for an indefinite period of time. Therefore, we no longer consider these aliens to be PRUCOL for SSI purposes.

There has been recent litigation, *Flores* v. *Bowen*, 790 F.2d 740 (9th Cir. 1986) in which the Ninth Circuit Court of Appeals found a *Silva* alien to be PRUCOL for SSI purposes because paragraph (a)(3) of § 416.1618 was still in the regulation. However, the court noted our Notice of Proposed Rulemaking and stated that the government was free to revoke the existing regulation which provides that *Silva* aliens are PRUCOL. Therefore, we have deleted this provision from the final regulations. *Silva* aliens may, of course, establish that they are PRUCOL if they can show that they meet any of the categories specified in the regulations.

Recent legislation, the Immigration Reform and Control Act of 1986, provides that aliens who have continuously resided in the U.S. illegally since before January 1, 1982 can apply for and be granted temporary legal residence status. After 18 months, the aliens can apply for and be granted permanent legal residence. While the new law generally prohibits newly legalized aliens from receiving Federal assistance, it excepts SSI. The legislative history of the law indicates that aliens granted temporary legal residence status would be residing in the U.S. under color of law. In addition, aliens granted such status would meet the definition of PRUCOL as specified in the *Berger* court orders and set out in § 416.1618(a) of these final regulations. Therefore, we will consider aliens granted temporary legal residence status to be PRUCOL for SSI purposes. The law also provides that certain seasonal agricultural workers can also apply for and be granted temporary legal residence status and after a specified period, permanent legal residence. Under the new legislation, these aliens are considered permanent residents and thus eligible for SSI. The statute also changes the registry date in section 249 of the Immigration and Nationality Act (8 U.S.C. 1259) from June 30, 1948 to January 1, 1972. While we have changed § 416.1618(b)(13) to include the new registry date we have not changed the regulations at this time to add a specific category for aliens who will be legalized under the new law. Since our categories generally refer to INS documents and procedures, we will revise these regulations as necessary after INS has developed regulations, procedures and documentation to implement the new legalization process.

Discussion of Comments

As previously indicated, we received a number of comments on the Notice of Proposed Rulemaking published in the **Federal Register** on March 19, 1986 (51 FR 9462). A summary of the comments and our responses follow.

Comment: Two commenters suggested that we delete the documents listed in § 416.1618(b) of the proposed regulation because the list was not exclusive. The commenters offered an alternative if the list of documents is to be retained. They suggested including language that makes it clear that these are the most common documents, but not the only ones.

Response: We believe it is helpful to mention the most common documents held by aliens; however, we did not intend this list to be exclusive. Therefore, we have not deleted the list but have revised § 416.1618(b) to make it clear that the listed documents are the most common ones aliens will have.

Comment: Two commenters suggested that the aliens included as PRUCOL under § 416.1618(d) of the proposed regulation be included as a category in the list in § 416.1618(b).

Response: We have adopted this suggestion and have added a new subparagraph (16) to § 416.1618(b) to cover this group.

Comment: Two commenters suggested that the regulation make clear that the term "does not contemplate enforcing departure" applies to only some of the categories listed in the proposed regulation.

Response: We have revised the regulation to make it clear that, under the court's order, a determination that INS does not contemplate enforcing departure must be made only for aliens in categories specified in § 416.1618(b) (5), (6), (7), (10), (14), and (16).

Comment: Two commenters stated that the proposed regulation at § 416.1618(c) would give SSA the authority to deny benefits to aliens with a status valid for an indefinite time period.

Response: We did not intend for the regulation to give the impression that an alien with a currently valid indefinite status would not be found to be PRUCOL. We have revised § 416.1618(d) to make it clear that aliens in categories specified in § 416.1618(b) (1), (2), (3), (4), (8), (9), (11), (12), (13), or (15) are PRUCOL as long as the document presented as evidence of that category is currently valid. However, as stated in our previous response, under the district court's order, we must make a determination of PRUCOL based on whether INS contemplates enforcing the departure of aliens in categories in § 416.1618(b) (5), (6), (7), (10), (14), and (16). Therefore, if an alien presents a document as evidence of one of these categories and the document indicates the status is indefinite, we will assume that INS does not contemplate enforcing departure. We will verify with INS that the indefinite status is currently valid. If INS verifies that the indefinite status is current and valid, this is sufficient proof that INS does not contemplate enforcing the alien's departure. Therefore, the individual will be considered to PRUCOL.

Comment: Two commenters suggested that an alien with a document valid for 1 year, 6 months, or for any period less than a year but with renewals totaling 1 year, be considered as one whose departure INS does not contemplate enforcing. This finding would be based on INS' policy and practice of not enforcing departure during the time allowed by the status.

Response: The district court's order requires us to determine PRUCOL based on whether INS contemplates enforcing the departure of aliens in categories in § 416.1618(b) (5), (6), (7), (10), (14), and (16). However, the order does not address at what point INS contemplates enforcing departure. We have interpreted the order as meaning "does not contemplate enforcing departure" at the expiration of a definite status; otherwise, the requirement of a determination of "does not contemplate enforcing departure" would be redundant. If INS has granted a definite status, it clearly will not deport during the pendency of that status.

Comment: Three commenters suggested that we pay aliens (if all other SSI eligibility factors are met) with a status valid for less than 1 year if we do not receive a response from INS within either 21 or 30 days. When we receive an answer from INS, we should follow normal overpayment procedures, if necessary. In a similar comment, it was suggested that we not verify alien status with INS at all. The commenters are

concerned that alien SSI applicants will lack funds to sustain themselves while their applications are being processed.

Response: We are not accepting these comments. INS has informed us and our experience has confirmed that INS does not renew indefinitely statuses valid for less than 1 year. Therefore, we cannot assume that INS does not contemplate enforcing the departure of these aliens. Accordingly, we will not begin payments until we receive verification from INS. As indicated earlier, under the courts' orders, SSA determines that an alien is PRUCOL based on INS intentions. We do not have any basis for assessing INS intentions without consulting with INS. In addition, we have worked with INS Central Office in the past and are currently doing so to assure timely responses to SSA verification requests.

Comment: One commenter believed that it is unnecessary to address suspension and overpayment rules in this regulation.

Response: We believe the references are necessary for clarity.

Comment: One commenter believed that the regulation implies that INS will make the determination as to whether it contemplates enforcing an alien's departure. The commenter stated that this determination should be made by SSA.

Response: We did not intend for the regulation to give the impression that INS will make the PRUCOL determination. That determination is part of the SSI eligibility determination made by SSA. SSA will make the PRUCOL determination based on information from INS as to its intent regarding enforcing the departure of an alien. Our operating instructions provide for us to send a form to INS that asks a series of specific questions as to INS' knowledge about the alien, the alien's status and INS' intentions regarding the alien. We specifically ask the questions: "Is it INS policy or practice to enforce the departure of aliens in this category?" and "Based on the facts in this individual's case, will INS permit this individual to reside in the United States indefinitely?". Based on INS' responses to the questions as to whether it contemplates enforcing departure, we will determine whether an alien is PRUCOL. We have revised § 416.1618(d) to make this clear.

Comment: Two commenters suggested that we further define the term "does not contemplate enforcing departure" as INS ". . . has no current plans to enforce your departure and will not do so as long as the factors bearing upon your status remain unchanged."

Response: We are not accepting the commenters' definition. As noted in an earlier response, we interpret the court order to mean "does not contemplate enforcing departure" at the expiration of a status for a definite time. To adopt the commenters' definition would result in a "does not contemplate enforcing departure" determination for all aliens during the pendency of a status for a definite time. We believe this result exceeds the scope of the court order.

Comment: One commenter suggested that unless INS has taken an actual step toward enforcing the departure of an alien within 2 weeks of his or her application for SSI, SSA should determine that the alien is PRUCOL.

Response: We are not adopting this comment because we believe it exceeds the scope of the court's order. This order does not require that INS take an actual step to enforce departure. Rather, it requires only that INS is not contemplating the enforcement of the alien's departure to find that the alien is PRUCOL.

Comment: One commenter suggested that we add to the list of categories aliens from specific countries, such as Uganda, Ethiopia, or nationals from Poland for whom INS has made a special determination that allows them to remain in the U.S.

Response: The district court's order requires SSA to "regularly request from INS information concerning other categories of aliens whose departure from the United States INS does not contemplate enforcing" and to "periodically revise the Program Operations Manual and regulations to reflect such categories." As the court's order demonstrates, the court considers "category" to mean a specific status. In implementing the court's order, we have followed the court's approach, but at the suggestion of commenters, have added an additional paragraph designed to cover aliens who do not come within the specified categories, but still meet the general definition of permanent residence under color of law under the court's order. The INS policies to which the commenter refers appear to be based on the changing political conditions in particular countries. Since those conditions, and therefore INS policies, can change quickly, we do not believe it is appropriate to codify those policies in regulations, which must be changed pursuant to Administrative Procedure Act notice and comment rulemaking procedures. We will consult with INS regularly to request information on other categories of aliens whose departure INS does not contemplate enforcing.

Since some of these aliens for whom INS makes a special determination that allows them to remain in the U.S. will have dated documents, under the rules in § 416.1618(d)(3), payments would not be made in all cases until after INS confirmed the current status and provided information which indicates that it did not contemplate enforcing departure. Since we know that INS renews the status of aliens from countries for whom INS has made a special determination that allows them to remain in the U.S. due to conditions in their country, we are revising § 416.1618(d)(3)(ii) to allow payment to these aliens prior to INS verification.

Comment: Two commenters suggested that the regulation make it clear that neither applicants for INS status nor nonimmigrants are PRUCOL.

Response: We agree and have clarified § 416.1618(b) accordingly.

Comment: One commenter suggested that aliens described in § 416.1618(b)(5) ". . . aliens on whose behalf an immediate relative petition has been approved . . ." should be excluded since this status does not mean the aliens are PRUCOL.

Response: We are required by the court's order to include this category.

Comment: One commenter suggested deleting § 416.1618(b)(6) (aliens who have filed applications for adjustment of status under section 245 of the Immigration and Nationality Act) and § 416.1618(b)(14) (aliens granted a suspension of deportation under section 244 of the Immigration and Nationality Act) as they are lawful permanent residents and, therefore, not subject to this regulation.

Response: We have not deleted § 416.1618(b)(14). Section 244 of the Immigration and Nationality Act allows for an immigration judge to issue an order to suspend deportation. This order does not confer lawful permanent resident status. If Congress takes no action on the alien's case in two legislative sessions, the alien is granted lawful permanent resident status. We agree with the comment regarding section 245 of the Immigration and Nationality Act in part and have deleted reference only to the granting of adjustment of status in § 416.1618(b)(6) since this does confer lawful permanent resident status. We had included this category in the NPRM because it was contained in the district court's order. We have added this category to § 416.1615, which sets out the rules for lawful permanent residence. We have left the remainder of § 416.1618(b)(6) intact, i.e., applicants for adjustment of status are still included in this category.

Comment: One commenter requested that the preamble be clarified to explain that this regulation applies only to the SSI program.

Response: We have revised the preamble accordingly.

Comment: One commenter suggested that proof of an indefinite status include a document with no expiration date, as well as a document annotated "indefinite."

Response: We are not adopting this suggestion since a document with no expiration date is not always evidence of an indefinite status. There are some documents with no expiration date which are provided for short periods of time and others which are provided to applicants for a status. INS does not intend these documents to be indicative of an indefinite status. The document is given to an alien, in some cases, until a decision is made on a permanent status. It would, therefore, be inappropriate for us to assume that INS does not contemplate enforcing the departure of an alien with a document with no expiration date. Since we have no proof, prior to INS contact, as to whether INS contemplates enforcing these aliens' departure, we will treat these aliens under § 416.1618(d)(3)(iii).

Comment: One commenter pointed out two technical citation errors. Section 416.1618(b)(6) of the proposed rules cited 8 CFR 242.5 (a) or (b) rather than 8 CFR 245.2(a) (1) or (2) and § 416.1618(b)(12) of the proposed rules cited 8 U.S.C. 252(d) rather than 8 U.S.C. 1252(d).

Response: We have made these technical corrections. We have also corrected the citation in § 416.1618(b)(7) dealing with stays of deportation from 8 U.S.C. 1253(a) to 8 U.S.C. 1105a.

Comment: One commenter suggested that we retain as a category of aliens PRUCOL, aliens who hold a *Silva* letter.

Response: We are not adopting this comment. The prior regulation was promulgated solely to implement the *Silva* v. *Levi* injunction by recognizing that those protected by it were to be deemed "permanently residing" so long as the injunction indefinitely prevented such aliens' removal. On December 18, 1981, the district court dissolved the injunction effective November 1, 1981.

As the Ninth Circuit Court of Appeals held in *Flores* v. *Bowen,* 790 F.2d 740 (9th Cir. 1986), the government is free to repeal the existing regulation that provides that *Silva* aliens are PRUCOL. Therefore, this category of alien is deleted and the *Silva* letter is not sufficient documentation that an alien is PRUCOL. However, if the alien has evidence of a status other than that of a *Silva* alien, that status will be evaluated under this final regulation.

Comment: One commenter suggested that we delete the reference in § 416.1618(c)(3) of the proposed regulation to whether INS "will continue to renew your status" and therefore does not contemplate enforcing your departure because often INS will not renew the alien's current status, but will instead grant a change in status.

Response: We agree and have deleted the reference.

Comment: One commenter provided a redraft of the regulation.

Response: Since there was no supporting rationale received within the comment period, we are unable to respond to this comment.

Regulatory Procedures

Executive Order 12291

The Secretary in consultation with the Office of Management and Budget, has determined that this rule is not a major rule under the terms of Executive Order 12291, therefore a regulatory impact analysis is not required. In addition, the Secretary has determined that these final regulations would not have a significant economic impact on a substantial number of small entities.

Paperwork Reduction Act

These final rules contain information collection requirements. As required by section 3507 of the Paperwork Reduction Act of 1980, we submitted a copy of the rules to the Office of Management and Budget (OMB) for its review of these information collection requirements. The reporting requirements contained in §§ 416.1615 and 416.1618 have been cleared by OMB under control number 0960–0451. Other organizations and individuals desiring to submit comments on the information collection requirements were requested in the Notice of Proposed Rulemaking to send them to us and to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building, Room 3208, Washington, DC 20503, Attention: Desk Officer for Health and Human Services. No comments were received on the information collection requirements.

Regulatory Flexibility Act

We certify that these regulations will not have a significant economic impact on a substantial number of small entities since they will affect only individuals and States. Therefore, a regulatory flexibility analysis as provided in Pub. L. 96–354, the Regulatory Flexibility Act, is not required.

(Catalog of Federal Domestic Assistance Program No. 13.807, Supplemental Security Program)

List of Subjects in 20 CFR Part 416

Administrative practice and procedure, Aged, Blind, Disability benefits, Public assistance programs, Supplemental Security Income.

Dated: November 4, 1986.

Dorcas R. Hardy,

Commissioner of Social Security.

Approved: December 24, 1986.

Otis R. Bowen,

Secretary of Health and Human Services.

PART 416—[AMENDED]

Part 416 of Chapter III of title 20 of the Code of Federal Regulations is amended as follows:

1. The authority citation for Subpart P of Part 416 is revised to read as follows:

Authority: Secs. 1102, 1614, and 1631, of the Social Security Act, as amended; 42 U.S.C. 1302, 1382c, and 1383.

2. In § 416.1615, paragraph (a) is amended by revising (a) (2) and (3) and by adding (a)(4) to read as follows:

§ 416.1615 How to prove you are lawfully admitted for permanent residence in the United States.

* * * * *

(2) A reentry permit;

(3) An alien identification card issued by the government of the Northern Mariana Islands showing that you are admitted to the Northern Mariana Islands for permanent residence; or

(4) Any document which shows that you have been granted lawful permanent resident status under section 245 of the Immigration and Nationality Act.

* * * * *

(Approved by the Office of Management and Budget under control number 0960–0451)

3. Section 416.1618 is revised to read as follows:

§ 416.1618 When you are considered permanently residing in the United States under color of law.

(a) *General.* We will consider you to be permanently residing in the United States under color of law and you may be eligible for SSI benefits if you are an alien residing in the United States with the knowledge and permission of the Immigration and Naturalization Service and that agency does not contemplate enforcing your departure. The Immigration and Naturalization Service does not contemplate enforcing your departure if it is the policy or practice of that agency not to enforce the departure of aliens in the same category or if from all the facts and circumstances in your case it appears that the Immigration and Naturalization Service is otherwise

permitting you to reside in the United States indefinitely.

(b) *Categories of aliens who are permanently residing in the United States under color of law.* Aliens who are permanently residing in the United States under color of law are listed below. None of the categories include applicants for an Immigration and Naturalization Service status other than those applicants listed. None of the categories allows SSI eligibility for nonimmigrants; for example, students or visitors. Also listed are the most common documents that the Immigration and Naturalization Service provides to aliens in these categories:

(1) Aliens admitted to the United States pursuant to 8 U.S.C. 1153(a)(7), (section 203(a)(7) of the Immigration and Nationality Act). We ask for INS Form I-94 endorsed "Refugee-Conditional Entry";

(2) Aliens paroled into the United States pursuant to 8 U.S.C. 1182(d)(5) (section 212(d)(5) of the Immigration and Nationality Act) including Cuban/Haitian Entrants. We ask for INS Form I-94 with the notation that the alien was paroled pursuant to section 212(d)(5) of the Immigration and Nationality Act. For Cuban/Haitian Entrants, we ask for INS Form I-94 stamped "Cuban/Haitian Entrant (Status Pending) reviewable January 15, 1981. Employment authorized until January 15, 1981." (Although the forms bear this notation, Cuban/Haitian Entrants are admitted under section 212(d)(5) of the Immigration and Nationality Act.);

(3) Aliens residing in the United States pursuant to an indefinite stay of deportation. We ask for an Immigration and Naturalization Service letter with this information or INS Form I-94 with such a notation;

(4) Aliens residing in the United States pursuant to an indefinite voluntary departure. We ask for an Immigration and Naturalization Service letter or INS Form I-94 showing that a voluntary departure has been granted for an indefinite time period;

(5) Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for a copy of INS Form I-94 or I-210 letter showing that status;

(6) Aliens who have filed applications for adjustment of status pursuant to section 245 of the Immigration and Nationality Act (8 U.S.C. 1255) that the Immigration and Naturalization Service has accepted as "properly filed" (within the meaning of 8 CFR 245.2(a) (1) or (2)) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for INS Form I-181 or a passport properly endorsed;

(7) Aliens granted stays of deportation by court order, statute or regulation, or by individual determination of the Immigration and Naturalization Service pursuant to section 106 of the Immigration and Nationality Act (8 U.S.C. 1105a) or relevant Immigration and Naturalization Service instructions, whose departure that agency does not contemplate enforcing. We ask for INS Form I-94 or a letter from the Immigration and Naturalization Service, or copy of a court order establishing the alien's status;

(8) Aliens granted asylum pursuant to section 208 of the Immigration and Nationality Act (8 U.S.C. 1158). We ask for INS Form I-94 and a letter establishing this status;

(9) Aliens admitted as refugees pursuant to section 207 of the Immigration and Nationality Act (8 U.S.C. 1157) or section 203(a)(7) of the Immigration and Nationality Act (8 U.S.C. 1153(a)(7)). We ask for INS Form I-94 properly endorsed;

(10) Aliens granted voluntary departure pursuant to section 242(b) of the Immigration and Nationality Act (8 U.S.C. 1252(b)) or 8 CFR 242.5 whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for INS Form I-94 or I-210 bearing a departure date;

(11) Aliens granted deferred action status pursuant to Immigration and Naturalization Service Operations Instruction 103.1(a)(ii) prior to June 15, 1984 or 242.1(a)(22) issued June 15, 1984 and later. We ask for INS Form I-210 or a letter showing that departure has been deferred;

(12) Aliens residing in the United States under orders of supervision pursuant to section 242 of the Immigration and Nationality Act (8 U.S.C. 1252(d)). We ask for INS Form I-220B;

(13) Aliens who have entered and continuously resided in the United States since before January 1, 1972 (or any date established by section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259). We ask for any proof establishing this entry and continuous residence;

(14) Aliens granted suspension of deportation pursuant to section 244 of the Immigration and Nationality Act (8 U.S.C. 1254) and whose departure the Immigration and Naturalization Service does not contemplate enforcing. We ask for an order from the immigration judge;

(15) Aliens whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)). We ask for an order from an immigration judge showing that deportation has been withheld; or

(16) Any other aliens living in the United States with the knowledge and permission of the Immigration and Naturalization Service and whose departure that agency does not contemplate enforcing.

(c) *How to prove you are in a category listed in paragraph (b) of this section.* You must give us proof that you are in one of the categories in paragraph (b) of this section. You may give us—

(1) Any of the documents listed in paragraph (b) of this section; or

(2) Other information which shows that you are in one of the categories listed in paragraph (b) of this section.

(d) *We must contact the Immigration and Naturalization Service.* (1) We must contact the Immigration and Naturalization Service to verify the information you give us to prove you are permanently residing in the United States under color of law.

(2) If you give us any of the documents listed in paragraphs (b) (1), (2), (3), (4), (8), (9), (11), (12), (13), or (15) of this section, we will pay you benefits if you meet all other eligibility requirements. We will then contact the Immigration and Naturalization Service to verify that the document you give us is currently valid.

(3) If you give us any of the documents listed in paragraphs (b) (5), (6), (7), (10) or (14) of this section, or documents that indicate that you meet category (16), or any other information to prove you are permanently residing in the United States under color of law, we will contact the Immigration and Naturalization Service to verify that the document or other information is currently valid. We must also get information from the Immigration and Naturalization Service as to whether that agency contemplates enforcing your departure. We will apply the following rules:

(i) If you have a document that shows that you have an Immigration and Naturalization Service status that is valid for an indefinite period we will assume that the Immigration and Naturalization Service does not contemplate enforcing your departure. Therefore, we will pay you benefits if you meet all other eligibility requirements. If, based on the information we get from the Immigration and Naturalization Service, we find that

your document is currently valid, we will consider this sufficient proof that the Immigration and Naturalization Service does not contemplate enforcing your departure. We will continue your benefits. However, if we find that your document is not currently valid, we will suspend your benefits under § 416.1321.

(ii) If you have a document that appears currently valid and shows you have an Immigration and Naturalization Service status for at least 1 year, or that shows the Immigration and Naturalization Service is allowing you to remain in the United States for a specified period due to conditions in your home country, we will assume that the Immigration and Naturalization Service does not contemplate enforcing your departure. Therefore, we will pay you benefits if you meet all other eligibility requirements. If, based on the information we get from the Immigration and Naturalization Service, we learn that your document is currently valid and that agency does not contemplate enforcing your departure, we will continue your benefits. However, if we learn that your document is not currently valid or that the Immigration and Naturalization Service does contemplate enforcing your departure, we will suspend your benefits under § 416.1321.

(iii) If you have a document that shows you have an Immigration and Naturalization Service status valid for less than 1 year, or if your document has no expiration date, or if you have no document, we will not pay you benefits until the Immigration and Naturalization Service confirms that your document is currently valid and we get information from that agency that indicates whether it contemplates enforcing your departure. If that agency does not contemplate enforcing your departure, we will pay you benefits if you meet all other eligibility requirements.

(iv) If at any time after you begin receiving benefits we receive information from the Immigration and Naturalization Service which indicates that the Immigration and Naturalization Service contemplates enforcing your departure, we will suspend your benefits under § 416.1321 and any benefits you have received after the date that the Immigration and Naturalization Service began contemplating enforcing departure will be overpayments under Subpart E of this Part.

(e) *What "United States" means.* We use the term "United States" in this section to mean the 50 States, the District of Columbia, and the Northern Mariana Islands.

(Approved by the Office of Management and Budget under control number 0960-0451)

[FR Doc. 87-12987 Filed 6-9-87; 8:45 am]
BILLING CODE 4190-11-M

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

23 CFR Part 668

Emergency Relief

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Final rule.

SUMMARY: The FHWA is revising its regulation on Emergency Relief (ER). Emergency Relief is a program established by Congress to assist the States in the repair of highways seriously damaged as the result of natural disasters or catastrophic failures. The regulation specifies procedures for program and project administration and provides guidance on eligibility of work. The final rule brings the existing regulation up to date considering recent legislative and administrative changes in the program, including the Federal-Aid Highway Act of 1987.

EFFECTIVE DATE: June 10, 1987.

FOR FURTHER INFORMATION CONTACT: Mr. James A. Carney, Railroads, Utilities and Programs Branch, Office of Engineering (202) 426-0450, or Mr. Michael J. Laska, Office of the Chief Counsel (202) 366-1383, Federal Highway Administration, 400 7th Street SW., Washington, DC 20590. Office hours are from 7:45 a.m. to 4:15 p.m. ET, Monday through Friday, except legal holidays.

SUPPLEMENTARY INFORMATION:

Background:

On September 17, 1985 (50 FR 37688) the FHWA published Docket No. 85-5, a notice of proposed rulemaking for Emergency Relief. The clear purpose of the ER program is to assist State and local authorities in unusually heavy expenses associated with an emergency involving Federal-aid highways. In carrying out the requirements of 23 U.S.C. 125 to provide funds to pay for the repair or reconstruction of Federal-aid highways, which are found to have suffered serious damage by natural disasters over a wide area or catastrophic failures, the Secretary of Transportation is authorized by 23 U.S.C. 315 to prescribe and promulgate rules and regulations. This authority is delegated to the Federal Highway Administrator by 49 CFR 1.48. The regulation, 23 CFR 668, establishes the authority and responsibility of the Federal Highway Administrator to approve funds on the basis of an occurrence qualifies as a disastrous situation with regard to serious highway damage and which work may be included as necessary to repair such damage.

Upon submission of an application by the SHA, FHWA reviews the submitted information and approves or disapproves the application according to the information provided.

The FHWA allocates ER funds to the States on the basis of estimates made by FHWA in conjunction with the SHA. Since eligible projects are on Federal-aid systems, appropriate classes of regular Federal-aid funds are available for major repair or relocation work which permits greater flexibility in the development of repair projects. It is not the purpose of this program to provide funds for instances of isolated damage to road facilities which as a matter of normal road operations should be routinely budgeted and provided for by the States; nor is it the intent of this program to compensate for a lack of State assistance to local agencies within the State. States and local authorities (through the States) should not seek ER funding for routine repairs or correction of normally expected road damage. This type of road damage should be funded through regular road fund contingency plannning. The ER program should be considered as a "last resort" to be used when an emergency situation goes beyond that which could and should reasonably be accommodated by a State's maintenance, emergency or contingency programs. Therefore, the inability of State or local authorities to pay is not in itself a warranting criterion to justify the approval of ER funds.

There can be no nationwide definitive break point between routine and extraordinary repair expenses. However, as a general rule, FHWA considers situations where a State's total estimated cost of work necessary to correct potential ER eligible sites is less than $500,000 per disaster to be of a nature which could be handled under its routine procedures. This is not an absolute threshold, but it is a reasonable point where FHWA must more critically review proposals for lesser amounts and consider whether the situation meets the intent of the ER program.

Discussion of Comments:

The September 17, 1985, notice of proposed rulemaking (NPRM) proposed revisions which were intended to bring the current regulation up to date considering recent legislative and administrative changes in the program. Forty-two comments on the NPRM were received within the 90-day comment period. Twenty-two agencies and individuals provided written responses. Seven of the comments related to general issues and to the preamble. The breakdown of the number of other comments by section were as follows: Definitions—11, Policy—9, Federal share payable—4, Eligibility—7, Application procedures—4. Twenty-two of the comments were accommodated in the final rule either by directly incorporating suggested language, or by rewording proposed language. Three suggestions related to provisions of law which could not be modified by regulation. Five responses were considered to be more appropriately categorized as non-regulatory and will be incorporated in future policy guidance for the program. The remaining twelve comments were considered, but not used for various reasons outlined further below.

The subject of each area which generated a response is discussed in the following narrative along with the nature of the comment and its disposition.

Several responses were received which related to the phrase in the preamble's Background of the NPRM, "as a general rule FHWA considers situations where the estimated cost of work necessary to correct potentially ER eligible sites is less than $500,000 for a single occurrence in a State to be of a nature which could be handled by a State under its routine procedures." One State objected to the figure as a criterion which would severely impact maintenance funds. However, one State expressed pleasant surprise that such a low figure is considered in the realm of possibility for ER. Two respondents suggested the criterion be incorporated into the regulation. As a result, the provision has been clarified and added as a provision of § 668.109.

One comment related to the need to merge the ER program with the Federal Emergency Management Agency (FEMA) to simplify inspections and administration. Although this has merit, legislation would be required and it is not appropriate to address the situation in this regulation at this time. Other comments which would have required legislation were: The suggestion to change from a 100% Federal share to a pro-rata share based on Federal-aid system; the suggestion to provide a "grant-in-lieu" for sites of $50,000 or less or for any amount when the State/local share is greater than the Federal share; the concept of permitting maintenance of detours to be eligible; and the request to provide ER funds to provide for the same standards for replacement of bridges as for replacement of other facilities. Except for the pro-rata share issue which was changed by the 1987 Federal-aid Highway Act (Pub. L. 100-17, 101 Stat. 132), these comments could not be accommodated.

One State said that it is apparent that an attempt is being made to eliminate emergency funding for roads affectd in a catastrophic manner by landslides. Another respondent requested that slow moving slides be included as eligible. These were in reference to the elimination of the word, "landslides" from the list of examples of a natural disaster and to the addition of the term "sudden" in describing the characteristics of a natural disaster. Catastrophes are a major category of disaster which are specified to be eligible by 23 U.S.C. 125 and this rulemaking. The revised wording is intended to assure that ER funds are not expended for non-emergency occurrences which develop over sufficient time to permit use of other fund sources for appropriate corrective or preventive work. Examples of such situations include geologic land movements which have been ongoing but only recently affected a roadway and basin flooding over a long period of time for which preventive measures can be planned and budgeted. Catastrophic landslides have been and will continue to be eligible for ER funds under the criteria established. The term "sudden" was removed from the definition of "Natural disaster," since the term "disaster," particularly within the context of external natural forces conveys much the same meaning.

The definition of external cause was termed "appropriate" by several respondents, but called "not clear" by another who suggested deleting the words, "and not primarily the result of [pre-]existing conditions." While the pre-existing conditions may often be difficult to ascertain, it is considered necessary to retain the wording to assure that ER funds are used for unexpected occurrences which create emergency conditions, not for a long-standing problem which suffered "convenient" damage.

The definition of "Federal roads" was identified as inconsistent with Part 668, subpart B and alternate terminology was suggested. This has been adopted in the final rule.

One State and a county in another State suggested that the regulations would not conform with the law since the proposed rulemaking eliminated landslides as an example of a natural disaster. Upon receipt of the comments, a thorough legal review was performed and as a result, the term "landslides" has received particular attention and has been included in the definition of a natural disaster. The situation where landslides occur over a sufficiently wide area to be classifed as a natural disaster is extremely unlikely. Normally, the classification of an occurrence as a "natural disaster over a wide area" or a "catastrophic failure" will be self-evident. Landslides could occur spontaneously over a wide area, but this would be a rarity. If landslides over a wide area are attributable to heavy rains, the rainfall would be the natural disaster. If the landslides are localized and attributable to an external cause, a catastrophic failure may be justified, provided serious damage occurred. Wording has been changed to accommodate this situation.

The last sentence of the definition of "serious damage" should be deleted or clarified according to one State. The sentence refers to ". . . a proliferation of damage, minor in nature, . . ." as not being serious. FHWA agrees that a disastrous situation could arise where there are a large number of sites each with relatively minor damage resulting in an extensive accumulation of damage but where there are no sites classified as serious damage; however, the case would be rare. If it did occur, the overall situation could be considered serious damage and found to be appropriate for ER funding provided that the accumulated impact on the highway facility significantly and adversely affects the safe and useful operation of the highway facility. The net effect of minor damage at frequent intervals in a segment may be cause to conclude that serious damage occurred over an elongated site if it seriously impairs the safety and usefulness of the highway. These situations must be evaluated and considered on a case-by-case basis as to whether the nature of the damage is within the intent of the enabling legislation. The definition has been modified to adopt this comment.

One agency suggested that the definition of heavy maintenance be provided in the regulation and another commented that a minimum dollar threshold per site be used to determine what "heavy maintenance" is. This has been seriously considered in order to

eliminate confusion, provide a greater degree of consistency across jurisdictions and to be consistent with the $500,000 suggested criteria for a disaster as a whole. Consideration has been given to the average annual maintenance cost per mile incurred by agencies maintaining the Federal-aid systems and to the apparent need to supply guidance as to the level of financing which could be anticipated from Federal sources in order to permit State and local planning and budgeting. FHWA recognizes that no dollar figure can be absolute, and providing such guidance which disregards inflation and special circumstances is done only upon evaluating the problems which have occurred without such guidance in the past. As a result, a $3,000 per site minimum is suggested for national consistency to encourage the FHWA Divisions, States and local agencies to agree upon a limiting value, not as a target, but as good faith effort to maintain the integrity and viability of the ER program as one which is available to reimburse States and local agencies for serious damage in times of greatest need.

The wording of § 668.105(d) regarding how a disaster is to be assessed for applicability and approval for ER funds was revised to accommodate a comment from one agency which suggested revising the first sentence to, "The approval to use available emergency . . ."

The need to require the States to consider national defense needs when prioritizing construction was encouraged by one agency. This is not considered a necessary regulatory provision.

Several suggestions were received which related to the two-year criteria to advance a project to the obligation stage. One State said two years may not be enough for complex work, especially if environmental or permit issues are involved; they suggested that the field report could identify such problem areas and an extension would be inherent in the approval of the disaster. Another agency stated that the time should be reduced since the serious need for emergency work is questionable when two or more years is allowed for obligation of funds. One commenter agreed with the provision and another asked that it be strengthened to require the "removal" of funds when the time limit expires. Funds are allocated to the FHWA Regional offices for use on a disaster basis. It is necessary for the State and FHWA field offices to assure that projects are promptly advanced to construction. A special de-allocation is considered unnecessary. The two-year provision is derived from legislative intent regarding availability of the annual authorization. Based upon experience as well as the comments received, the time limit is considered appropriate as is.

Additional documentation was perceived as a problem by one State which stated that the requirement for a State determination of public interest in § 668.105(i) could be eliminated by rewording the section. This has been done.

Guidance was requested as to how the limitation per disaster per State is to be administered considering the need to fund Federal-aid system damage as well as damage to Federal roads out of the same limited amount. General guidance has been added to § 668.107(b) and the limitation has been raised to $100 million as provided in the 1987 Federal-Aid Highway Act.

The six-week time frame for submission of a field report documenting the nature and extent of a disaster was questioned by two respondents. One stated that it is too long a time as detailed reports are not appropriate at a time when State and local agencies need to know if assistance is going to be provided. Another said that it is too short a time because sufficient information to justify and document a disaster is difficult to provide in less than eight weeks. Providing detailed reports on the initial field review can mean only one series of field inspections may be needed rather than going back after the finding has been made by the Administrator. Neither suggestion was adopted since the purpose of reducing the time frame for the field report is to encourage administration of a true emergency in an expedited manner. There may be instances where detailed reporting can be accomplished at the time of the initial field reviews to the extent that subsequent inspections are obviated. However, this practice should be limited to catastrophic failures and other disasters in a limited geographic area where the field report would not be delayed. The Administrator needs evidence of an independent FHWA assessment of eligible damage in an area recommended for ER funds. This may be accomplished by a detailed description, photo and an estimate of one or more damage sites per county or other political jurisdiction along with an estimate of total damage for each such area to clearly demonstrate that serious damage exists therein. It is essential, however, that every effort be made to establish in the field report the actual scope and nature of the overall damage in each affected political subdivision as well as the best estimate of overall costs by jurisdiction.

Three comments regarded 668.109(c)(7) relating to the eligibility of deficient bridges scheduled for replacement. One wanted to know what "scheduled for replacement" means. One state that such a facility should be eligible as long as the cause was the disaster and not the deficient condition. The other said that ER should be disallowed only if other Federal-aid funds had been authorized for replacement prior to the disaster. This section has been modified to clarify the meaning of "scheduled for replacement" but the provision itself has been retained to assure ER funds are not used to supplant other Federal funds which would have been used had the disaster not occurred.

Summary of Revisions

The revisions are intended to bring the existing regulation up to date considering recent legislative and administrative changes in the program. Generally, the changes include: (1) Recent legislative provisions in the 1987 Federal-aid Highway Act and the 1982 Surface Transportation Assistance Act [Pub. L. 97.424, 96 Stat. 2133-2134] (1982 STAA) (a) placing a $100 million limitation on the amount of ER funds which can be obligated on a particular disaster in a State, (b) establishing the Federal share based on the Federal-aid system on which damage occurred except 100 percent for emergency repairs to minimize damage, protect facilities, or restore essential traffic accomplished within 90 days after the actual occurrence of the natural disaster or catastrophic failure, and (c) adding more definitive eligibility language; (2) simplifying program procedures; and (3) clarifying of the wording of several sections to assure more consistent coordination and review of proposed projects. Specific revisions are as follows:

Section 668.103

Definitions—The definition of "catastrophic failure" is clarified by emphasizing that a highway failure must result from an external cause as specified in 23 U.S.C. 125. The term "external cause" is added as a definition. The definition of "natural disaster" is clarified to include the condition "sudden." Definitions for "heavy maintenance," "serious damage," and "State" are added.

Section 668.105

Policy—This section is amended to: (1) add a paragraph to restate a longstanding policy that ER funds are not intended to supplant other funds for correction of pre-existing, non-disaster related deficiencies; (2) add a paragraph providing for cost effectiveness; i.e., that ER funds should be expended so as to

reduce, to the greatest extent feasible, the cost of permanent restoration work; and (3) clarify the provision for prompt crediting when insurance or other compensatory proceeds are involved.

Section 668.107

Federal Share Payable—This section provides that the Federal share is based on the Federal-aid system on which damage occurred except that it is 100 percent for emergency repairs to minimize damage, protect facilities, or restore essential traffic accomplished within 90 days after the acutual occurrence of the natural disaster or catastrophic failure. It is presumed that it will be a rare occurrence when a State would request a lesser Federal share, but it is permitted if the State so elects. It would most likely occur for projects covered by a disaster for which eligible costs exceed the amount which may be expended from the ER account.

Section 668.109

Eligibility—This section is amended to: (1) specifically list the activities which are not eligible for ER funds and (2) clarify that the total cost of a project eligible for ER may not exceed the cost of repair or reconstruction of a comparable facility.

Section 668.111

Application Procedures—This section is amended to: (1) simplify the application procedure by eliminating the need to specify the State's form of intent and (2) clarify the provision for the field report on the natural disaster or catastrophic failure by specifically outlining the content requirements.

Section 668.113

Program and Project Procedures—This section is amended to simplify the procedures for program implementation, including providing for alternative procedures, and to assure expeditious funding.

Regulatory Impact

The FHWA has determined that this document contains neither a major rule under Executive Order 12291 nor a significant regulation under the regulatory policies and procedures of the Department of Transportation. The revisions in this document are primarily in technical in nature, provide language clarifications, and provide a more current delineation of legislative mandates. The revisions are not expected to impose additional burdens on the States or local agencies and should reduce implementation burdens by providing a more current regulation and procedural simplifications. For these reasons, the anticipated economic impact, if any, will be minimal. Therefore, a full regulatory evaluation is not required. For the same reasons and under the criteria of the Regulatory Flexibility Act [Pub. L. 96-354], the FHWA hereby certifies that this action will not have a significant economic impact on a substantial number of small entities.

With regard to the statutory provisions mandated by the Federal-Aid Highway Act of 1987 which have been included in this final rule, the FHWA has determined that good cause exists to make these provisions effective without prior notice and opportunity for comment pursuant to 5 U.S.C. (b)(3)(B). Since these provisions merely reflect statutory language mandated by the 1987 Act, public comment is unnecessary. Notice and opportunity for comment are not required under the regulatory policies and procedures of the Department of Transportation because it is not anticipated that such action could result in the receipt of useful information because the provisions incorporated in the regulation require no interpretation and provide for no discretion. Accordingly, the regulation will become effective upon publication in the **Federal Register.**

In consideration of the foregoing, FHWA is revising Part 668, Subpart A of title 23, Code of Federal Regulations, to read as set forth below.

(Catalog of Federal Domestic Assistance Program No. 20.205, Highway Planning and Construction. The regulations implementing Executive order 12372 regarding intergovernmental consultation on Federal programs and activities apply to this program)

List of Subjects in 23 CFR Part 668

Grant program—transportation, Highways and roads, Emergency relief, Reporting and recordkeeping requirements.

Issued on: June 2, 1987.

R.A. Barnhart,

Federal Highway Administrator.

Part 668 is amended by revising Subpart A to read as follows:

PART 668—EMERGENCY RELIEF

Subpart A—Procedures for Federal-aid Highways

Sec.

Authority: 23 U.S.C. 101, 120(f), 125 and 315; 42 U.S.C. 5155; 49 CFR 1.48(b).

§ 668.101 Purpose.

To establish policy and provide program guidance for the administration of emergency funds for the repair or reconstruction of Federal-aid highways, which are found to have suffered serious damage by natural diasters over a wide area or serious damage from catastrophic failures. Guidance for application by Federal agencies for reconstruction of Federal roads not on the Federal-aid system is contained in 23 CFR Part 668, Subpart B.

§ 668.103 Definitions.

In addition to others contained in 23 U.S.C. 101(a), the following definitions shall apply as used in this regulation:

(a) *Applicant*—The State highway agency is the applicant for Federal assistance under 23 U.S.C. 125 for State highways and local roads and streets which are a part of the Federal-aid highway system.

(b) *Catastrophic failure*—The sudden failure of a major element or segment of the highway system due to an external cause. The failure must not be primarily attributable to gradual and progressive deterioration or lack of proper maintenance. The closure of a facility because of imminent danger of collapse is not in itself a sudden failure.

(c) *Emergency repairs*—Those repairs including temporary traffic operations undertaken during or immediately following the disaster occurrence for the purpose of:

(1) Minimizing the extent of the damage,

(2) Protecting remaining facilities, or

(3) Restoring essential travel.

(d) *External cause*—An outside force or phenomenon which is separate from the damaged element and not primarily the result of existing conditions.

(e) *Heavy maintenance*—Work usually done by highway agencies in repairing damage normally expected from seasonal and occasionally unusual natural conditions or occurrences. It includes work at a site required as a direct result of a disaster which can reasonably be accommodated by a State or local road authority's maintenance, emergency or contingency program.

(f) *Natural disaster*—A sudden and unusual natural occurrence, including but not limited to intense rainfall, floods, hurricanes, tornadoes, tidal waves, landslides, volcanoes or earthquakes which cause serious damage.

(g) *Proclamation*—A declaration of emergency by the Governor of the affected State.

(h) *Serious damage*—Heavy, major or unusual damage to a highway which severely impairs the safety or usefulness of the highway or results in road closure. Serious damage must be beyond the scope of heavy maintenance.

(i) *State*—Any one of the United States, the District of Columbia, Puerto Rico or the Virgin Islands, Guam, American Samoa or Commonwealth of the Northern Mariana Islands.

§ 668.105 Policy.

(a) The Emergency Relief (ER) program is intended to aid States in repairing road facilities which have suffered widespread serious damage resulting from a natural disaster over a wide area or serious damage from a catastrophic failure.

(b) ER funds are not intended to supplant other funds for correction of preexisting, nondisaster related deficiencies.

(c) The expenditure of ER funds for emergency repair shall be in such a manner so as to reduce, to the greatest extent feasible, the cost of permanent restoration work.

(d) The approval to use available ER funds to repair or restore highways damaged by a natural disaster shall be based on the combination of the extraordinary character of the natural disturbance and the wide area of impact as well as the seriousness of the damage. Storms of unusual intensity occurring over a small area may not meet the above conditions.

(e) ER funds shall not duplicate assistance under another Federal program or compensation from insurance or any other source. Partial compensation for a loss by other sources will not preclude emergency fund assistance for the part of such loss not compensated otherwise. Any compensation for damages or insurance proceeds including interest recovered by the State or political subdivision must be used upon receipt to reduce ER fund liability on the project.

(f) Prompt and diligent efforts shall be made by the State to recover repair costs from the legally responsible parties to reduce the project costs particularly where catastrophic damages are caused by ships, barge tows, highway vehicles, or vehicles with illegal loads or where damage is increased by improperly controlled objects or events.

(g) The processing of ER requests shall be given prompt attention and shall be given priority over non-emergency work.

(h) ER projects shall be promptly constructed. Any project that has not advanced to the construction obligation stage by the end of the second fiscal year following the disaster occurrence will not be advanced unless suitable justification to warrant retention is furnished to the FHWA.

(i) Permanent repair and reconstruction work, not accomplished as emergency repairs, shall be done by the contract method unless the State Highway agency adequately demonstrates that some other method is more cost effective as described in 23 CFR 635.204. Emergency repair work may be accomplished by the contract, negotiated contract or highway agency force account methods as determined by the Highway agency as best suited to protect the public health and safety.

(j) ER program funding is only to be used to repair highways which have been seriously damaged and is not intended to fund heavy maintenance or routine emergency repair activities which should normally be funded as contingency items in the State and local road programs. An application for ER funds in the range of $500,000 or less must be accompanied by a showing as to why the damage repair involved is considered to be beyond the scope of heavy maintenance or routine emergency repair. As a general rule, widespread nominal road damages in this range would not be considered to be of a significant nature justifying approval by the FHWA Administrator for ER funding.

§ 668.107 Federal share payable.

(a) The Federal share payable on account of any repair or reconstruction provided for by funds made available under 23 U.S.C. 125 of this title on account of any project on a Federal-aid highway system, including the Interstate System, shall not exceed the Federal share payable on a project on such system as provided in 23 U.S.C. 120; except that the Federal share payable for eligible emergency repairs to minimize damage, protect facilities, or restore essential traffic accomplished within 90 days after the actual occurrence of the natural disaster or catastrophic failure may amount to 100 percent of the costs thereof.

(b) Total obligations of ER funds in any State, excluding Puerto Rico or the Virgin Islands, Guam, American Samoa or Commonwealth of the Northern Mariana Islands, for all projects (including projects on both the Federal-aid systems and those on Federal roads under 23 CFR Part 668, Subpart B), resulting from a single natural disaster or a single catastrophic failure, shall not exceed $100 million per disaster or catastrophic failure. The total obligations for ER projects in any fiscal year in Puerto Rico, the Virgin Islands, Guam, American Samoa and the Commonwealth of the Northern Mariana Islands shall not exceed $5 million. Upon receipt of the field reports and estimates, allocations of available funds will be made by FHWA Headquarters in Washington, DC.

§ 668.109 Eligibility

(a) The eligibility of all work is contingent upon approval by the Federal Highway Administrator of an application for ER and inclusion of the work in an approved program of projects.

(1) Prior FHWA approval or authorization is not required for emergency repairs and preliminary engineering (PE).

(2) Permanent repairs or restoration must have prior FHWA program approval and authorization, unless done as part of the emergency repairs.

(b) ER funds may participate in:

(1) Repair to or reconstruction of seriously damaged highway elements as necessary to restore the facility to pre-disaster conditions, including necessary clearance of debris and other deposits in drainage courses within the right-of way (ROW);

(2) Restoration of stream channels outside the highway ROW when:

(i) The public highway agency has responsibility for the maintenance and proper operation of the stream channel section, and

(ii) The work is necessary for satisfactory operation of the highway system involved;

(3) Actural PE and construction engineering costs on approved projects;

(4) Emergency repairs;

(5) Temporary operations, including emergency traffic services such as flagging traffic through inundated sections of highways, undertaken by the applicant during or immediately following the disaster; and

(6) Betterments, such as relocation, replacement, upgrading or other added features not existing prior to the disaster, only where clearly economically justified to prevent future recurring damage. Economic justification must weigh the cost of the betterment against the risk of eligible recurring damage and the cost of future repair.

(c) ER funds may not participate in:

(1) Heavy maintenance to repair damage not directly associated with serious damage to the road consisting primarily of eroded shoulders, filled ditches and culverts, pavement settlement, mud and debris deposits, slope sloughing, minor slides, and slip-outs in cut or fill slopes which do not extend to the travelled way. In order to simplify the inspection and estimating process, heavy maintenance may be defined using dollar guidelines developed by the States and Divisions with Regional concurrence.

(2) Repair of surface damage caused by traffic whether or not the damage

was aggravated by saturated subgrade or inundation, unless such traffic was necessary for emergency repairs of seriously damaged sections of the road;

(3) Repair of damage not directly related to, and isolated away from, the pattern of the disaster;

(4) Maintenance of detours and temporary surfaces, upon completion of emergency repairs and prior to permanent reconstruction;

(5) Replacement of damaged or lost material not incorporated into the highway such as stockpiled materials or items awaiting installation;

(6) Repair or reconstruction of facilities affected by long-term, pre-existing conditions or predictable developing situations such as flooding in basin areas or slow moving slides;

(7) Permanent repair or replacement of deficient bridges scheduled for replacement with other funds. "Scheduled" means included in the approved Federal-aid program, the current or next fiscal year's Highway Bridge Replacement and Rehabilitation Program or included in contract plans being prepared; and

(8) Other normal maintenance and operation functions on the highway system.

(d) Replacement highway facilities are appropriate when it is not technically and economically feasible to repair or restore a seriously damaged element to its predisaster condition and are limited in ER reimbursement to the cost of a new facility to current design standards of comparable capacity and character to the destroyed facility. With respect to a bridge, a comparable facility is one which meets current geometric and construction standards for the type and volume of traffic it will carry during its design life.

(e) Except as otherwise provided in paragraph (b)(6) of this section, the total cost of a project eligible for ER funding may not exceed the cost of repair or reconstruction of a comparable facility. ER funds may participate to the extent of eligible repair costs when proposed projects contain unjustified betterments or other work not eligible for ER funds.

§ 668.111 Application procedures.

(a) *Notification*—As soon as possible after the disaster, the applicant shall notify the FHWA Division Administrator of its intent to apply for ER funds.

(b) *Field report*—As soon as practical after the occurrence, the State will promptly make a preliminary field survey, working cooperatively with the FHWA Division Administrator and other governmental agencies with jurisdiction over eligible highways. The preliminary field survey should be coordinated with the Federal Emergency Management Agency work, if applicable, to eliminate duplication of effort. The purpose of this survey is to determine the general nature and extent of damage to eligible highways for preparation of a field report by the FHWA Division Administrator.

(1) The purpose of the field report is to provide a factual basis for the Federal Highway Administrator's finding that serious damage to Federal-aid highways has been caused by a natural disaster over a wide area or a catastrophe. The report should include by political subdivision or other generally recognized administrative or geographic boundaries, a description of the types and extent of damage to highways and a preliminary estimate of cost of restoration or reconstruction for Federal-aid systems in each jurisdiction. To the extent available, similar information on other roads should be included. A description of the nature and characteristics of the natural disaster or catastrophe, and dates of occurrence (incident period), should be coordinated with the Federal Emergency Management Agency (FEMA) and included in the report. When the President has declared "a major disaster," detailed information on the extraordinary natural disturbance is not required; however, the seriousness of the road damage must be documented. Pictures showing the kinds and extent of damage and sketch maps detailing the damage areas should be included in the field report.

(2) Unless very unusual circumstances prevail, receipt of the field report should be prepared within 6 weeks following the applicant's notification.

(c) *Application*—Before funds can be made available, an application for ER must be made to, and approved by the FHWA Administrator. The application shall be submitted to the FHWA Division Administrator, who will forward it through channels to FHWA Headquarters. The application shall include:

(1) A copy of the Governor's proclamation or request for a Presidential proclamation; and

(2) A copy of the field report.

(d) *Approval of application*—The Federal Highway Administrator's approval of the application constitutes the finding of eligibility under 23 U.S.C. 125 and shall constitute approval of the application.

(Information collection requirements approved by the Office of Management and Budget under Control No. 2125-0525)

§ 668.113 Program and project procedures.

(a) Immediately after approval of an application, the FHWA Division Administrator will notify the applicant to proceed with preparation of a program consistent with requirements of 23 CFR Part 630. The program should define the work needed to restore or replace the damaged facilities and be submitted to the FHWA Division Administrator within 3 months of receipt of this notification. The FHWA field office will assist the applicant and other affected agencies in preparation of the program. This work may involve joint site inspections to view damage and reach tentative agreement on type of permanent corrective work to be undertaken. Program data should be kept to a minimum, but should be sufficient to identify the approved disaster or catastrophe and to permit a determination of the eligibility and propriety of proposed work. If the field report is determined by the FHWA Division Administrator to be of sufficient detail to meet these criteria, additional program support data need not be submitted.

(b) Project procedures:

(1) Projects for permanent repairs shall be processed in accordance with regular Federal-aid procedures except as modified herein or with approved Certification Acceptance procedures where applicable.

(2) Simplified procedures, including abbreviated plans should be used where appropriate.

[FR Doc. 87-13184 Filed 6-9-87; 8:45 am]

BILLING CODE 4910-22-W

NAVAJO AND HOPI INDIAN RELOCATION COMMISSION

25 CFR Part 700

Housing Benefit Determination; Replacement Housing Payments

May 19, 1987.

AGENCY: Navajo and Hopi Indian Relocation Commission.

ACTION: Interim final rule with request for comments.

SUMMARY: This rule amends the current Commission procedure for determining replacement housing pursuant to Pub. L. 99-500 which directed the Commission to calculate housing benefits consistent with a Solicitor's opinion of the Department of Interior dated August 25, 1986.

DATES: Interim Final Rule effective June 10, 1987. Comments must be received on or before July 10, 1987.

ADDRESS: Comments may be mailed to the Executive Director, Navajo and Hopi Indian Relocation Commission, P.O. Box KK, Flagstaff, Arizona 86002.

FOR FURTHER INFORMATION CONTACT: E. Susan Crystal (Attorney), Navajo and Hopi Indian Relocation Commission, at (602) 779-2721.

SUPPLEMENTARY INFORMATION: Pub. L. 99-500 making continuing appropriations for fiscal year 1987 included language directing the Commission to change its method of computing replacement housing benefits for those subject to relocation pursuant to Pub. L. 93-531, 25 U.S.C. 640d, et. seq. The Appropriations Bill provides that "for certified eligible households for whom a benefit level has not been determined, such level shall hereafter be determined consistent with the interpretation of 25 U.S.C. 640d-14 issued by the Solicitor of the Department of the Interior on August 25, 1986."

At the present time, the Commission practice is to calculate housing benefits pursuant to 25 U.S.C. 640d-14 by adding the value of the improvements owned by the relocatee on land from which he must move to the amount allowed by 25 U.S.C. 640d-14(b)(2). At the present time, this additional amount is $55,000 for a family of three or less and $66,000 for a family of four or more. If, for example, a family owns $5,000 worth of improvements on land partitioned to the tribe of which they are not members and has a family of three, they would be entitled to $55,000 plus $5,000 for a total of $60,000. These funds would be utilized for the purchase or construction of their replacement home.

The Commission's existing regulations allow for a variety of methods for calculating housing benefits. To clarify the benefit levels in accordance with the Congressional directive, the Commission is amending its existing interpretive regulations. The Solicitor's Opinion of August 25, 1986 was prepared at the request of the Assistant Secretary for Indian Affairs. The 1986 Interior Appropriations Bill (Pub. L. 99-500) provided funds to the Bureau of Indian Affairs to construct relocation homes on lands acquired in Arizona and New Mexico for relocation purposes. The August 25th opinion state that, the appropriation benefit determination methodology under 25 U.S.C. 640d-14 is to take the appraisal value and add only that amount needed (up to the statutory cap) to build a replacement dwelling. This means that $55,000 for a family of 3 or less and $66,000 for a family of 4 or more would be the maximum amounts available for decent, safe and sanitary replacement dwellings from the Commission's housing appropriation.

The Commission is amending its regulations by deleting the existing 25 CFR 700.183(a) and replacing it with a new section which spells out the revised method of calculating replacement housing benefits. The amount of the benefit is presently a maximum of $55,000 for a family of three or less and $66,000 for a family of four or more. This amount may be adjusted by the Commission based on an annual review of housing costs pursuant to 25 U.S.C. 640-14(b)(2). The value of the habitation and improvements owned by a relocatee on land partitioned to a tribe of which he is not a member will be applied first toward the cost of a replacement dwelling, pursuant to 25 U.S.C. 640d-14(b)(2). An additional amount will then be added to provide for the reasonable cost of a decent, safe, and sanitary dwelling. The total amount available for a replacement home will not exceed the amount established pursuant to 25 U.S.C. 640d-14(b)(2). If a relocatee has an appraisal that exceeds the amount of replacement home benefit to which he is entitled, he will be paid the difference in cash.

The Commission is publishing this rule as an interim final rule to become effective upon publishing in the FR. This is necessary because the Commission has a number of clients who are ready to select their relocation homes and sign relocation contracts. If there is a delay, the Commission may not be able to relocate its projected 200 families during F.Y. 1987. A number of these families have been awaiting benefits for as long as five years and have no permanent dwelling while awaiting receipt of their benefits. It is critical that the Commission continue to proceed with the relocation effort.

Pub. L. 99-500 provides that this calculation shall be applied for anyone who has not yet had their benefits determined by the Commission. The Commission issues two letters—a family size benefit letter, and an appraisal value letter. All relocatees who have received both letters are considered by the Commission to have had their benefits determined and not covered by this amended regulation.

List of Subjects in 25 CFR Part 700

Administrative practice and procedure, Conflict of interests, Freedom of Information, Grant program—Indians, Real property acquisition, Relocation assistance.

PART 700—[AMENDED]

Accordingly 25 CFR Part 700 is amended as follows:

1. The authority citation for Part 700 is revised to read as follows:

Authority: Pub. L. 99-590; Pub. L. 93-531, 88 Stat. 1712 as amended by Pub. L. 96-305, 94 Stat. 929 (25 U.S.C. 640d).

2. In Subpart E, § 700.183(a) is revised to read as follows:

§ 700.183 Determination of replacement housing benefit.

(a) Amount of benefit—The replacement housing benefit for a certified eligible head-of-household is an amount not to exceed Fifty-Five Thousand Dollars ($55,000) for a household of three or less and not to exceed Sixty-Six Thousand Dollars ($66,000) for a household of four or more. Subject to such other requirements of these regulations as may apply, the replacement housing benefit shall be calculated as follows;

(1) The amount of the fair market value of the habitation and improvements purchased from an eligible head-of-household pursuant to Subpart B of this part shall be applied first toward the cost of a replacement dwelling.

(2) An additional amount shall be added to the value of the habitation and improvements to equal the cost of a decent, safe, and sanitary replacement dwelling.

(3) The total value of the replacement dwelling shall not exceed the amount of the replacement housing benefit specified in paragraph (a) of this section.

(4) In the event the cost of providing a decent, safe, and sanitary replacement dwelling is less than the fair market value of the habitation and improvements purchased from an eligible head-of-household pursuant to Subpart B of this part, the difference shall be paid to that head-of-household.

* * * * *

Hawley Atkinson,

Chairman, Navajo and Hopi Indian Relocation Commission.

[FR Doc. 87-12734 Filed 6-9-87; 8:45 am]

BILLING CODE 6820-BB-M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1952

California State Plan; Resumption of Concurrent Federal Enforcement

AGENCY: Department of Labor, Occupational Safety and Health Administration (OSHA).

ACTION: Resumption of exercise of concurrent Federal enforcement authority in the State of California.

SUMMARY: This document provides notice of the resumption of concurrent Federal enforcement authority in California under section 18(e) of the Occupational Safety and Health Act of 1970 (hereinafter called "the Act") (29 U.S.C. 667(e)) effective July 1, 1987. California Governor George Deukmejian has indicated his intention to end California's participation as a State with an OSHA-approved occupational; safety and health plan effective June 30, 1987. The effect and finality of the Governor's action are under dispute in both the California State legislature and courts. Until such time as these issues are resolved, the Occupational Safety and Health Administration will assume responsibility for concurrent enforcement of Federal occupational safety and health standards in all private sector workplaces in the State of California beginning July 1, 1987.

EFFECTIVE DATE: July 1, 1987.

FOR FURTHER INFORMATION CONTACT: James Foster, Director, Office of Information and Consumer Affairs, Occupational Safety and Health Administration, Room N3647, 200 Constitution Avenue, NW, Washington, DC, 20210, Telephone (202) 523-8148.

SUPPLEMENTARY INFORMATION:

Background

Part 1954 of Title 29, Code of Federal Regulations, sets out procedures under section 18 of the Act for the evaluation and monitoring of State plans which have been approved under section 18(c) of the Act and 29 CFR Part 1902. In States which have received initial plan approval under section 18(c), the Act provides that OSHA "may, but shall not be required to" exercise Federal enforcement authority concurrently with the State. 29 U.S.C. 667(e); See *Environmental Improvement Division* v. *Marshall*, 661 F.2d 860 (10th Cir. 1981). OSHA regulations at 29 CFR 1954.3 provide guidelines and procedures for the exercise of discretionary Federal enforcement authority with regard to Federal standards in issues covered under an approved State plan. In accordance with § 1954.3(b) of those regulations, Federal enforcement will not be exercised as to occupational safety and health issues covered under a State plan when a State is found to be "operational." A State is considered to be operational under § 1954.3(b) when it has provided for the following requirements: enacted enabling legislation; approved State standards; a sufficient number of qualified enforcement personnel; and provisions for the review of enforcement actions. In determining whether and to what extent a State plan meets the operational guidelines, the results of evaluations conducted under 29 CFR Part 1954 are taken into consideration. Once this determination has been made under § 1954.3(f) of this chapter, OSHA may enter into an agreement with the State setting forth areas of Federal and State enforcement responsibility, and a summary of the agreement (usually referred to as an "operational status agreement") is published in the **Federal Register.**

The California State occupational safety and health plan was approved by OSHA under section 18(c) of the Act and 29 CFR Part 1902 on April 24, 1973. On May 1, 1973, a notice was published in the **Federal Register** announcing the approval and adding to 29 CFR Part 1952 a new Subpart K which generally described the plan. The Subpart included a list of the developmental steps which the State agreed that it would accomplish in order to meet the criteria for State plans set forth in §§ 1902.3 and 1902.4.

On September 30, 1975, upon determining that the California plan had developed sufficiently to warrant a suspension of concurrent Federal enforcement activity, Federal OSHA entered into an operational status agreement with the State of California. Under the terms of that agreement, OSHA voluntarily suspended the application of concurrent Federal enforcement authority with regard to Federal occupational safety and health standards in all issues covered by the California plan. A **Federal Register** notice was published on January 13, 1976 (41 FR 1904), announcing the operational status agreement and amending Subpart K of Part 1952 to reflect the terms of the agreement. On April 30, 1979, OSHA and the State amended the 1975 agreement by signing an addendum to clarify the circumstances under which concurrent Federal enforcement would be exercised, including among other circumstances the "... reduction of State resources of staff ..." (addendum to Operational Status Agreement, Paragraph 4).

On February 6, 1987, Governor George Deukmejian in a letter to Secretary of Labor William E. Brock notified the Department of Labor of his intention to discontinue the State of California's occupational safety and health program and to voluntarily withdraw the California State plan under 29 CFR 1955.3, effective June 30, 1987. Pursuant to that decision, preparations have been made by the State for terminating the operation of the State program. These preparations have resulted in a substantial reduction of staff. Governor Deukmejian also informed Secretary Brock that funds for State enforcement of occupational safety and health standards in the private sector would be eliminated as of July 1. Litigation is pending in State courts challenging the Governor's February 6, 1987 letter of intent and other actions which have been taken to terminate the plan. In addition, the State legislature is considering the Governor's proposal as part of the budgetary process. These actions have left the status of the California plan uncertain.

Exercise of Concurrent Federal OSHA Authority in California

The Assistant Secretary has determined that as a result of the uncertainty as to the status of the California plan as well as the substantial reduction of its staff and resources, the California State program as of July 1, 1987, will be unable to fully or effectively exercise its enforcement authority. Paragraph 4 of the April 30, 1979, addendum to OSHA's Operational Status Agreement with California provides that in such circumstances, resumption of Federal enforcement authority may occur.

Therefore, in order to assure the protection of California employees the exercise of full Federal concurrent enforcement authority and responsibility will be resumed in California on July 1, 1987. Federal standards contained in 29 CFR Parts 1910 (general industry), 1915 (shipyard employment), 1917 (marine terminals), 1918 (longshoring), 1919 (gear certification), 1926 (construction) and 1928 (agriculture) will be enforced in private sector employment in the State. Federal OSHA will conduct inspections of private sector workplaces in the State, including inspections in response to employee complaints of hazardous working conditions, and issue citations and propose penalties for violations of Federal standards and regulations as appropriate. Contests will be heard by

the Federal Occupational Safety and Health Review Commission. Federal authority will be exercised with regard to complaints alleging discrimination against private sector employees because of the exercise of any right afforded to the employee by the Act.

Complaints from private sector employees of hazardous working conditions or discrimination for exercising rights under the Act and all other inquiries with regard to Federal occupational safety and health enforcement in the private sector after June 30, 1987, should be directed to the OSHA Regional Office in San Francisco, at the following address: Regional Administrator, U.S. Department of Labor, OSHA, Room 11349, Federal Building, 450 Golden Gate Avenue, San Francisco, California, 94102, Telephone: (415) 556-0585.

Upon resolution of the administrative, legislative and judicial issues within the State of California, appropriate further Federal action will be taken with regard to the withdrawal or continuance of the California State plan.

(Secs. 8, 18, Occupational Safety and Health Act of 1970 (29 U.S.C. 657, 667); Secretary of Labor's Order No. 12-71 (36 FR 8754), 8-76 (41 FR 25059), or 9-83 (48 FR 35736), as applicable)

Signed this 5th day of June, 1987, in Washington, DC.

John A. Pendergrass,

Assistant Secretary of Labor.

[FR Doc. 87-13265 Filed 6-9-87; 8:45 am]

BILLING CODE 4510-26-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD7-87-1]

Drawbridge Operation Regulations; Outer Clam Bay, FL; Correction

AGENCY: Coast Guard, DOT.

ACTION: Final rule, correction.

SUMMARY: This document corrects a final rule on drawbridge requirements that appeared at page 9164 in the **Federal Register** of Monday, March 23, 1987 (52 FR 9164). The action is necessary to correct an error in the numbering of a new regulation. The new section was identified incorrectly as 117.321; it should have been identified as 117.323.

EFFECTIVE DATE: This regulation was effective on April 22, 1987.

FOR FURTHER INFORMATION CONTACT: Mrs. Zonia C. Reyes (305) 536-4103.

Correction: Accordingly, the Coast Guard is correcting FR Doc. 87-6214 appearing on pages 9163 and 9164 in the **Federal Register** issue of March 23, 1987. On page 9164, the text is corrected to read as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for Part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05-1(g).

2. Part 117 is amended by adding a new § 117.323 to read as follows:

§ 117.323 Outer Clam Bay.

The draw of the Clam Bay boardwalk shall open on signal between 9 a.m. and 5 p.m., if at least one-hour advance notice is given. Between 5 p.m. and 9 a.m., the draw will be left in the open position.

Dated: May 26, 1987.

H.B. Thorsen,

Rear Admiral, U.S. Coast Guard Commander, Seventh Coast Guard District.

[FR Doc. 87-12982 Filed 6-9-87; 8:45 am]

BILLING CODE 4910-14-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[PP 6E3378/R890; FRL-3215-4]

Pesticide Tolerance for Metolachlor

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This rule establishes a tolerance for the combined residues of the herbicide metolachlor and its metabolites in or on the raw agricultural commodity tabasco peppers. The Interregional Research Project No. 4 (IR-4) petitioned for this tolerance.

EFFECTIVE DATE: Effective on June 10, 1987.

ADDRESS: Written objections, identified by the document control number [PP 6E3378/R890], may be submitted to: Hearing Clerk (A-110), Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

FOR FURTHER INFORMATION CONTACT:

By mail: Donald R. Stubbs, Emergency Response and Minor Use Section (TS-767C), Registration Division, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460.

Office location and telephone number: Rm. 716B, CM #2, 1921 Jefferson Davis Highway, Arlington, VA 22202 (703-557-1806).

SUPPLEMENTARY INFORMATION: EPA issued a proposed rule, published in the **Federal Register** of April 15, 1987 (52 FR 12198), which announced that the Interregional Research Project No. 4 (IR-4), New Jersey Agricultural Experiment Station, P.O. Box 231, Rutgers University, New Brunswick, NJ 08903, had submitted pesticide petition 6E3378 to EPA on behalf of Dr. Robert H. Kupelian, National Director, IR-4 Project, and the Agricultural Experiment Station of Louisiana and the U.S. Department of Agriculture.

The petitioner requested that the Administrator, pursuant to section 408(e) of the Federal Food, Drug, and Cosmetic Act, propose the establishment of a tolerance for the combined residues of the herbicide metolachlor (2-chloro-*N*-(2-ethyl-6-methylphenyl)-*N*-(2-methoxy-1-methylethyl)acetamide) and its metabolites, determined as the derivatives, 2-[(2-ethyl-6-methylphenyl)amino]-1-propanol and 4-(2-ethyl-6-methylphenyl)-2-hydroxy-5-methyl-3-morpholinone, each expressed as the parent compound in or on the raw agricultural commodity tabasco peppers at 0.5 part per million (ppm). The petitioner proposed that this use of metolachlor on tabasco peppers be limited to Louisiana based on the geographical representation of the residue data submitted. Additional residue data will be required to expand the area of usage. Persons seeking geographically broader registration should contact the Agency's Registration Division at the address provided above.

There were no comments or requests for referral to an advisory committee received in response to the proposed rule.

The data submitted in the petition and all other relevant material have been evaluated and discussed in the proposed rule. Based on the data and information considered, the Agency concludes that the tolerance will protect the public health. Therefore, the tolerance is established as set forth below.

Any person adversely affected by this regulation may, within 30 days after publication of this document in the **Federal Register**, file written objections with the Hearing Clerk, at the address given above. Such objections should specify the provisions of the regulation deemed objectionable and the grounds for the objections. A hearing will be granted if the objections are supported by grounds legally sufficient to justify the relief sought.

The Office of Management and Budget has exempted this rule from the

requirements of section 3 of Executive Order 12291.

Pursuant to the requirements of the Regulatory Flexibility Act (Pub. L. 96-354, 94 Stat. 1164, 5 U.S.C. 601-612), the Administrator has determined that regulations establishing new tolerances or raising tolerance levels or establishing exemptions from tolerance requirements do not have a significant economic impact on a substantial number of small entities. A certification statement to this effect was published in the **Federal Register** of May 4, 1981 (46 FR 24950).

(Sec. 408(d), 68 Stat. 512 (21 U.S.C. 346a(d)).)

List of Subjects in 40 CFR Part 180

Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: May 26, 1987.

Douglas D. Campt,

Director, Office of Pesticide Programs.

PART 180—[AMENDED]

Therefore, Part 180 is amended as follows:

1. The authority citation for Part 180 continues to read as follows:

Authority: 21 U.S.C. 346a.

2. Section 180.368 is amended by removing the entry for "peppers, chili . . . 0.5" from the table in paragraph (a), by revising the introductory paragraphs to the list of commodities in paragraphs (a) and (b), and by adding paragraph (c), to read as follows:

§ 180.368 Metolachlor; tolerances for residues.

(a) Tolerances are established for the combined residues of the herbicide metolachlor (2-chloro-*N*-(2-ethyl-6-methylphenyl)-*N*-(2-methoxy-1-methylethyl)acetamide) and its metabolites, determined as the derivatives, 2-[(2-ethyl-6-methylphenyl)amino]-1-propanol and 4-(2-ethyl-6-methylpheny1)-2-hydroxy-5-methyl-3-morpholinone, each expressed as the parent compound in or on the following raw agricultural commodities:

* * * * *

(b) Tolerances are established for indirect or inadvertent residues of metolachlor in or on the following raw agricultural commodities when present therein as a result of the application of metolachlor to growing crops listed in paragraph (a) of this section to read as follows:

* * * * *

(c) Tolerances with regional registration as defined in § 180.1(n) are established for the combined residues of the herbicide metolachlor and its metabolites in or on the following raw agricultural commodities:

Commodities	Parts per million
Peppers, chili	0.5
Peppers, tabasco	.5

[FR Doc. 87-12965 Filed 6-9-87; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[CC Docket 85-229, Phase II; FCC 87-102]

Common Carrier Services; Replacement of Structural Separation With Nonstructural Safeguards for the Provision of Enhanced Services

AGENCY: Federal Communications Commission.

ACTION: Memorandum Opinion and Order; Denial of petition for reconsideration.

SUMMARY: The Commission acted on petitions seeking reconsideration or clarification of various aspects of the Third Computer Inquiry Phase I Order, which replaced the structural separation requirements of Computer II with nonstructural safeguards for the enhanced service operations of AT&T and the BOCs.

FOR FURTHER INFORMATION CONTACT: William F. Maher, Policy and Program Planning Division, Common Carrier Bureau (202) 632-4047.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Third Computer Inquiry Memorandum Opinion and Order on Reconsideration, CC Docket 85-229, adopted March 26, 1987, and released April 1987. The initiating document for this Memorandum Opinion and Order is the Third Computer Inquiry Report and Order (Phase I), CC Docket 85-229, 104 FCC 2d 958, released June 16, 1986 (51 FR 24350; July 3, 1986).

The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision also may be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

Summary of Memorandum Opinion and Order on Reconsideration

On June 16, 1986, the Federal Communications Commission (the Commission) released a Report and Order (the Phase I Order) in the Third Computer Inquiry (Computer III). The Phase I Order established requirements for replacing the structural separation requirements adopted in Computer II with nonstructural safeguards, including Comparably Efficient Interconnection (CEI) and Open Network Architecture (ONA), for the enhanced services operations of AT&T and the Bell Operating Companies (BOCs).

In response to petitions for reconsideration and clarification of the Phase I Order, the Commission released a Memorandum Opinion and Order on Reconsideration (the Reconsideration Order) on April 1987.

In the Reconsideration Order, the Commission determined that while AT&T is required to file a modified ONA plan on February 1, 1988, it is not required to implement the type of unbundling specified by the ONA requirements in the Phase I Order, but may rely, on service-specific CEI plans for integrated or collocated enhanced and basic services.

The Commission affirmed the review process of the Phase I Order for the CEI and ONA plans filed by the carriers. It also clarified that the filing of ONA plans is mandatory, not optional, for AT&T and the BOCs, and that the geographic coverage of CEI plans for specific enhanced services may be limited to the area in which a carrier is offering such services. The Commission further clarified that the CEI/ONA access standard remains "full technical equality," but that "equality as perceived by end users" is a key factor in fulfilling that standard.

The Commission affirmed the criteria established in the Phase I Order for determining the initial set of key BSEs, and clarified that initial sets of key BSEs may be deployed over limited geographic areas. The Commission determined that an initial set of key BSEs must be implemented within one year of approval of a carrier's ONA plan. It further held that carriers must specify in their ONA plans their schedules and procedures for the implementation of a full set of BSEs including the deployment of BSEs throughout their service areas. The Commission also clarified that unbundled BSEs, as well as the unbundled basic services for service-specific CEI, may be designed only to address the needs of enhanced service

providers. However, such BSEs and CEI services tariffed in the interstate jurisdiction must be available to any customer for any use. The Commission did not preempt the states, from imposing customer or use restrictions on intrastate BSEs or CEI services.

The Commission affirmed CEI/ONA pricing requirements of the Phase I Order, but did not preempt the states with regard to the pricing of such basic services.

The Commission affirmed its preemptive detariffing of enchanced services adopted in Computer II, as well as its actions in the Phase I Order that preempt the states from (a) imposing separate subsidiary requirements on the enhanced service operations of AT&T and the BOCs and (b) imposing nonstructural safeguards that are inconsistent with the Computer III safeguards.

Ordering Clauses

It is hereby ordered, that the Request to Exceed Page Limitation of Southwestern Bell is granted.

It is further ordered, that pursuant to 47 U.S.C. 151, 154(i) and (j), 201, 202, 203, 205, 218, and 405, and 5 U.S.C. 553, the Petitions for Reconsideration and Clarification filed in this proceeding are denied, except as provided herein.

William J. Tricarico,

Secretary.

[FR Doc. 87-13244 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-294; RM-5029, RM-5155, RM-5560]

Radio Broadcasting Services; Blackshear, Folkston and Richmond Hill, GA

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allots Channel 286A to Richmond Hill, Georgia, at the request of Ebony Broadcasting Company (RM-5155), and allots Channel 222A to Folkston, Georgia, in response to a counterproposal filed by Folkston Broadcasters, Inc. (RM-5560). The petition filed by Mattox-Guest, Inc., proposing to substitute Channel 286C2 for Channel 285A at Blackshear, Georgia, and modify its Class A license for Station WKUB(FM), is denied (RM-5560). With this action, this proceeding is terminated.

DATES: July 20, 1987. The window period for filing applications on Channel 286A at Richmond Hill and Channel 222A at Folkston will open on July 21, 1987, and close on August 19, 1987.

FOR FURTHER INFORMATION CONTACT: Montrose H. Tyree, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-294, adopted April 24, 1987, and released June 5, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Part 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments is amended for Georgia, by adding Richmond Hill, Channel 286A, and Folkston, Channel 222A.

Federal Communications Commission.

Bradley P. Holmes,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13230 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-134; RM-5144, RM-5520]

Radio Broadcasting Services; DeKalb and Mt. Morris, IL

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document (1) allots Channel 235A to DeKalb, Illinois, as a second FM service with a site restriction 11.3 kilometers west of the city at the request of Peggy Jo Martis; and (2) allots Channel 263A to Mt. Morris, Illinois, with a site restriction 8.7 kilometers northeast, in response to a counterproposal filed by Hometown Communications, Inc. With this action, this proceeding is terminated.

DATES: Effective Date: July 20, 1987. The window period for filing applications will open on July 21, 1987, and close on August 19, 1987.

FOR FURTHER INFORMATION CONTACT: Montrose H. Tyree, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-134, adopted May 5, 1987, and released June 5, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio braodcasting.

Part 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. In § 73.202(b), the Table of FM Allotments is amended in the entry for DeKalb, Illinois, by adding Channel 235A, and for Mt. Morris, Illinois, by adding Channel 263A.

Federal Communications Commission.

Mark N. Lipp,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13235 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-331; RM-5471; RM-5614]

Radio Broadcasting Services; Corinth, Hadley, Queensbury, NY

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allocates Channel 289B1 to Queensbury, New York, as the community's first local FM service, at the request of Bradmark Broadcasting Company. Channel 289B1 can be allocated to Queensbury in compliance with the Commission's minimum distance separation requirements with a site restriction of 19.5 kilometers (12.1 miles) south to avoid a short-spacing to the application of Station CFGL-FM, Channel 289C1, Laval, Quebec, Canada. The request of

Jedco Broadcasting Corporation to substitute Channel 289B1 for Channel 228A at Corinth, New York, and to modify the license of its Station WSCG-FM, is denied. Channel 228A is reallocated from Hadley, New York, to Corinth, to reflect its actual use there by Station WSCG-FM. Canadian concurrence in these allotments has been received. With this action, this proceeding is terminated.

DATES: Effective date: July 20, 1987. The window period for filing applications for Channel 289B1 at Queensbury will open on July 21, 1987, and close on August 19, 1987.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-331, adopted May 14, 1987, and released June 5, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments for New York is amended by adding Channel 289B1, Queensbury, Channel 228A, Corinth, and removing Channel 228A, Hadley.

Bradley P. Holmes,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13232 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-389; RM-5353]

Radio Broadcasting Services; Honeoye Falls, NY

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allocates Channel 297A to Honeoye Falls, New York, as the community's first local FM service, at the request of Monroe-Livingston Radio Ltd. Channel 297A can be allocated in compliance with the Commission's minimum distance separation requirements with a site restriction of 1.3 kilometers (0.8 miles) northeast to avoid a short-spacing to Station WUWU, Channel 299, Wethersfield, New York. The Commission has advised Emmy Hahn Limited Partnership, an applicant for Channel 294A at Irondeqoit, New York (ARN-861126MS) that it has improperly selected a transmitter site which conflicts with this allotment. Canadian concurrence in the allocation of Channel 297A at Honeoye Falls has been received. With this action, this proceeding is terminated.

DATES: Effective Date: July 20, 1987. The window period for filing applications for open on July 21, 1987, and close on August 19, 1987.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-389, adopted May 18, 1987, and released June 5, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments for New York is amended by adding Honeoye Falls, Channel 297A.

Mark N. Lipp,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13231 Filed 6-9-87; 8:45 a.m.]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-360; RM-5313]

Radio Broadcasting Services; Hope Mills, NC

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allocates Channel 278A to Hope Mills, NC, as the community's first local FM service, at the request of Cecil L. Boddie and James Christopher Parham Frank and John Gilmer Dawson III. Channel 278A can be allocated to Hope Mills in compliance with the Commission's minimum distance separation requirements with a site restriction of 3.8 kilometers (2.4 miles) east to avoid a short-spacing to Station WSOC-FM, Channel 279, Charlotte, NC. With this action, this proceeding is terminated.

DATES: Effective Date: July 20, 1987. The window period for filing applications will open on July 21, 1987, and close on August 19, 1987.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-360, adopted May 5, 1987, and released June 5, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202(b) [Amended]

2. Section 73.202(b), the Table of FM Allotments for North Carolina is amended by adding Hope Mills, Channel 278A.

Mark N. Lipp,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13233 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-65; RM-5138]

Radio Broadcasting Services; Havelock, NC

AGENCY: Federal Communications Commission

ACTION: Final rule.

SUMMARY: This document substitutes Channel 286C2 for Channel 285A at Havelock, North Carolina, at the request of Musicradio of North Carolina, Inc. and modifies its license for Station WMSQ(FM) to specify operation on the higher powered channel. Channel 286C2 can be allocated to Havelock in compliance with the Commission's minimum distance separation requirements with a site restriction of 16.7 kilometers (10.4 miles) southeast to avoid a short-spacing to Station WDCG at Durham, North Carolina. This substitution of channels is conditioned on the outcome of a pending appeal filed by Marine Broadcasting Corp. before the D.C. Circuit Court of Appeals to substitute Channel 287C2 for Channel 288A at Jacksonville, North Carolina, and the substitution of channels allocated to Fairbluff and Wilmington, North Carolina, in MM Docket 84-231, *Marine Broadcasting Corp.* v. *FCC and USA*, Case No. 86-1536. With this action, this proceeding is terminated.

EFFECTIVE DATE: July 20, 1987.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-65, adopted May 6, 1987, and released June 5, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

AUTHORITY: 47 U.S.C. 154, 303.

§ 73.202(b) [Amended]

2. Section 73.202(b), the Table of FM Allotments for Havelock, North Carolina, is amended by removing Channel 285A and adding Channel 286C2.

Mark N. Lipp,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13234 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-204; RM-5249, RM-5518]

Radio Broadcasting Services; Sullivan and Henniker, NH

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allocates Channel 256A to Henniker, NH, as the community's first local FM service, at the request of Clark Smidt. Channel 256A can be allocated to Henniker in compliance with the Commission's minimum distance separation requirements without a site restriction. Canadian concurrence in the allocation has been received since Henniker is located within 320 kilometers (200 miles) of the U.S.-Canadian border. The conflicting request of Gary M. Kenny to allocate Channel 256A to Sullivan, NH, as the community's first local FM service, is denied. With this action, this proceeding is terminated.

DATES: Effective date: July 20, 1987. The window period for filing applications will open on July 21, 1987, and close on August 19, 1987.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-204, adopted May 5, 1987, and released June 4, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202(b) [Amended]

2. Section 73.202(b), the Table of FM Allotments for New Hampshire is amended by adding Henniker, Channel 256A.

Bradley P. Holmes,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13237 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-262; RM-5295; RM-5344]

Radio Broadcasting Services; Cape Vincent, NY

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allocates Channel 274A to Cape Vincent, New York, as the community's first local FM service, as requested by Timothy J. Martz. Channel 274A can be allocated with a site restriction of 6.1 kilometers (3.8 miles) south to avoid a short-spacing to Station CBOF-FM, Ottawa, Ontario, Canada. Channel 234A cannot be allocated as Cape Vincent's second local FM service, as requested by Mars Hill Broadcasting Company, Inc., since it conflicts with a previously filed Canadian request to allocate Channel 233A to Brookville, Ontario, Canada. Canadian concurrence in the allocation of Channel 274A has been received. With this action, this proceeding is terminated.

DATES: Effective date July 20, 1987. The window period for filing applications will open on July 21, 1987, and close on August 19, 1987.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-262, adopted May 4, 1987, and released June 4, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202(b) [Amended]

2. Section 73.202(b), the Table of FM Allotments for New York is amended by adding Cape Vincent, Channel 274A.

Mark N. Lipp,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13238 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 86-327; RM-5333]

Radio Broadcasting Services; Sarles, ND

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: At the request of Timothy J. Martz, this document allocates Channel 290 to Sarles, North Dakota, as the community's first local FM service. Channel 290 can be allocated in compliance with the Commission's minimum distance separation requirements without the imposition of a site restriction. Canadian concurrence has been received since Sarles is located within 320 kilometers (200 miles) of the U.S.-Canadian border. With this action, this proceeding is terminated.

DATES: Effective July 20, 1987; The window period for filing applications will open on July 21, 1987, and close on August 19, 1987.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 86-327, adopted May 5, 1987, and released June 4, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW, Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW, Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments for North Dakota is amended by adding Sarles, Channel 290.

Mark N. Lipp,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13239 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 675

[Docket No. 61225-7052]

Groundfish of the Bering Sea and Aleutian Islands Area

AGENCY National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Notice of inseason adjustment.

SUMNMARY: NOAA announces the apportionment of amounts of Alaska groundfish to the joint venture processing (JVP) portion of the domestic annual harvest (DAH) under provisions of the Fishery Management Plan for the Groundfish Fishery of the Bering Sea and Aleutian Islands Area (FMP). Groundfish are apportioned according to the regulations implementing the FMP. The intent of this action is to assure optimum use of these groundfish by allowing the domestic fishery to proceed without interruption.

DATES: Effective June 5, 1987. Comments will be accepted through June 22, 1987.

ADDRESS: Comments should be mailed to Robert W. McVey, Director, Alaska Region, National Marine Fisheries Service, P.O. Box 1668, Juneau, AK 99802, or be delivered to Room 453, Federal Building, 709 West Ninth Street, Juneau, Alaska.

FOR FURTHER INFORMATION CONTACT: Janet E. Smoker (Resource Management Specialist, NMFS), 907-586-7230.

SUPPLEMENTARY INFORMATION: The FMP governs the groundfish fishery in the exclusive economic zone under the Magnuson Fishery Conservation and Management Act. The FMP was developed by the North Pacific Fishery Management Council (Council) and implemented by rules appearing at 50 CFR 611.93 and Part 675. The total allowable catches (TACs) for various groundfish species are apportioned initially among DAH, reserves, and total allowable level of foreign fishing (TALFF). The reserve amount, in turn, is to be apportioned to DAH and/or TALFF during the fishing year, under 50 CFR 611.93(c) and 675.20(b). As soon as practicable after April 1, June 1, August 1 and on such other dates as are necessary, the Secretary of Commerce apportions to DAH all or part of the reserve that he finds will be harvested by U.S. vessels during the remainder of the year, except that part or all of the reserve may be withheld if an apportionment would adversely affect the conservation of groundfish resources or prohibited species. No action was scheduled for the April 1 date because no need for adjustment to the initial specifications was apparent at that time. The initial specifications of domestic annual processing (DAP) and JVP (both components of DAH) for 1987 were based in part on the projected needs of the U.S. industry as assessed by a mail survey sent by the Regional Director to fishermen and processors in November 1986. The results of the survey indicated that the total DAH capacity for pollock in the Bering Sea subarea exceeded the TAC. After the fifteen percent of TAC was placed in the non-specific reserve, as required at § 675.20(a)(3), the initial specifications for Bering Sea pollock were determined as follows: for DAP, 189,987 mt; and for JVP, the remainder, 830,013 mt (52 FR 785, January 9, 1987).

On January 1, JVP was supplemented by 18,339 mt of the non-specific reserve, and TALFF by 10,071 mt of the non-specific reserve, including 5,000 mt to the Bering Sea pollock TALFF, to provide bycatch in foreign flatfish fisheries. On May 15, JVP was supplemented by 100,000 mt from the 271,590 mt non-specific reserve, reducing the non-specific reserve to 171,590 mt, (52 FR 18367).

TABLE 1.—BERING SEA/ALEUTIAN ISLANDS REAPPORTIONMENTS OF TAC

	Current	This action	Revised
Pollock: (Bering Sea Subarea) DAP	189,987		189,987
TAC=1,200,000; JVP	930,013	+75,000	1,005,013
EY=1,200,000 TALFF	5,000		5,000
Total (TAC=2,000,000)			
DAP	416,018		416,018
JVP	1,348,040	+75,000	1,423,040
TALFF	64,352		64,352
Reserves	171,590	−75,000	96,590

The following actions are taken by this notice to reapportion specifications in the BSA fisheries.

To the BSA-JVP

In the Bering Sea subarea, 65 U.S. catcher boats delivering fish to 33 foreign processors continue to conduct directed fisheries on pollock. To provide for continued JVP fishing in the Bering Sea for pollock, 75,000 mt of the non-specific reserve is apportioned to the Bering Sea pollock JVP. This is the maximum reserve amount that can be apportioned to the pollock TAC without resulting in a TAC greater than the equilibrium yield (EY). When the pollock JVP is taken, current regulations require that all joint venture vessels discard pollock in the same manner as prohibited species. The Regional Director estimates that the entire pollock JVP could be taken by the directed pollock fishery by mid-June. Thus, pollock taken in joint venture fisheries for other groundfish species would be wasted for the remaining half-year. In order to prevent such wastage and encourage the full utilization of all pollock harvested, the Secretary is providing only 55,000 mt of the reserve apportionment for harvest in the directed pollock joint venture fishery. The Regional Director estimates that the additional amount will be taken by June 6, 1987.

The Regional Director estimates that the remaining JVP tonnage of groundfish target species other than pollock would require a bycatch amount of 20,000 mt of pollock. Therefore, the remaining 20,000 mt of the 75,000 non-specific reserve is apportioned to the Bering Sea pollock JVP in accordance with 50 CFR 675.20(b)(1)(i) on the condition that it be used only for bycatch in JVP fisheries that continue to conduct directed fisheries on species other than pollock in the Bering Sea subarea after June 6. Thus, U.S. vessels participating in joint ventures may continue fishing for other groundfish species after June 6 and retain pollock provided that their take of pollock does not exceed 20 percent of their take as defined at 50 CFR 675.2.

This apportionment does not result in overfishing of the pollock stock, as the resulting TAC is 1.2 million mt, equal to the equilibrium yield (EY).

Comments and Responses

In accordance with 50 CFR 611.92(c) and 675.20(b), aggregated reports on U.S. catches of Alaska groundfish and the processing of those groundfish were available for public inspection to facilitate informed public comment. In addition, those provisions afforded the public an opportunity to submit comments on the extent to which U.S. fishermen will harvest and the extent to which U.S. processors will process Alaska groundfish. One written comment was received.

Comment: The remaining reserve of pollock should be approved for release on a timely basis to permit continuous joint venture operations.

Response: The maximum reserve amount possible without resulting in a pollock TAC greater than EY is being released at this time. The current JVP pollock fisheries will be able to continue until June 6 without interruption.

Classification

This action is taken under the authority of 50 CFR 675.20(b) and complies with Executive Order 12291.

The Assistant Administrator for fisheries finds for good cause that it is impractical and contrary to the public interest to provide prior notice and comment. Immediate effectiveness of this notice is necessary to benefit fishermen who otherwise would have to forego substantial amounts of other groundfish species if fishing were closed as a result of achieving previously specified JVPs or TACs. However, interested persons are invited to submit comments in writing to the address above for 15 days after the effective date of this notice.

List of Subjects in 50 CFR Part 675

Fisheries.

Authority: 16 U.S.C. 1801, *et seq.*

Dated: June 4, 1987.

James E. Douglas, Jr.,

Deputy Assistant Administrator for Fisheries, National Marine Fisheries Service.

[FR Doc. 87-13160 Filed 6-5-87; 10:46 am]

BILLING CODE 3510-22-M

Proposed Rules

Federal Register
Vol. 52, No. 111
Wednesday, June 10, 1987

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 925

Grapes Grown in a Designated Area of Southeastern California—Additional Packing Holiday for the 1987 Season Only

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Proposed rule.

SUMMARY: This proposed rule would suspend the Independence Day packing holiday for handlers of California desert grapes currently scheduled for Friday, July 3, 1987, and substitute therefor Monday, July 6, 1987. This modification would apply to the 1987 season only. This action is necessary in order to counter slow table grape sales activity during the week following the Independence Day holiday. It was recommended by the California Desert Grape Administrative Committee, which works with the Department in administering the Federal marketing order for California desert grapes.

DATES: Comments due June 30, 1987.

ADDRESSES: Comments should be sent to: Docket Clerk, Fruit and Vegetable Division, AMS, USDA, Room 2085 South Building, Washington, DC 20250–1400. Two copies of all written material should be submitted, and they will be made available for public inspection in the office of the Docket Clerk during regular business hours.

FOR FURTHER INFORMATION CONTACT: James M. Scanlon, Acting Chief, Marketing Order Administration Branch, F&V, AMS, USDA, Washington, DC 20250–1400, telephone (202) 475–3914.

SUPPLEMENTARY INFORMATION: This proposed rule has been reviewed under Departmental Regulation 1512–1 and Executive Order 12291 and has been determined to be a "non-major" rule under criteria contained therein.

Pursuant to requirements set forth in the Regulatory Flexibility Act (RFA), the Administrator of the Agricultural Marketing Service has determined that this action would not have a significant economic impact on a substantial number of small entities.

The purpose of the RFA is to fit regulatory actions to the scale of business subject to such actions in order that small businesses will not be unduly or disproportionately burdened. Marketing orders issued pursuant to the Agricultural Marketing Agreement Act of 1937, as amended (the Act, 7 U.S.C. 601–674), and rules promulgated thereunder, are unique in that they are brought about through the group action of essentially small entities acting on their own behalf. Thus, both statutes have small entity orientation and compatibility.

Grapes grown in the production area are marketed in the major market areas of the United States. Shipments of California desert grapes totaled 8,189,994 million lugs (22 pound equivalent) in 1986. This is compared to 7,491,364 million lugs in 1985 and the three year (1983–1985) average of 6,899,377 million lugs. Since 1982, bearing acreage of California desert grapes has increased moderately. Bearing acreage was reported at 18,073 acres in 1986, slightly more than the 15,994 acres in 1985.

There are approximately 22 handlers of California desert grapes subject to regulation under the marketing order handling regulation. There are approximately 88 growers of desert grapes in the production area. Small agricultural producers have been defined by the Small Business Administration (13 CFR 121.2) as those having annual gross revenues for the last three years of less than $100,000, and agricultural service firms are defined as those whose gross annual receipts are less than $3,500,000. The majority of handlers and producers of table grapes may be classified as small entities.

The regulatory action in this instance is a proposed rule which would suspend the Friday, July 3, 1987, Independence Day packing holiday and substitute therefor Monday, July 6 as the packing holiday for handlers of California desert grapes. This change would apply to the 1987 season only. This action was recommended by the California Desert Grape Administrative Committee at a public meeting on November 20, 1986.

California Desert Grape Regulation 6 (§ 925.304; 52 FR 8865) prohibits handlers from packing grapes on Saturdays, Sundays, Memorial Day, and Independence Day. The purpose of these packing holidays is to promote market stability by avoiding an oversupply of grapes in marketing channels. Section 925.304(e) authorizes the committee to modify or suspend these holidays.

Under the current handling regulation, the officially observed Independence Day packing holiday this season would be Friday, July 3. Due in part to this holiday, most wholesale and terminal markets will be closed on Friday, July 3. The Los Angeles Wholesale Terminal Market, which receives a substantial percentage of grapes shipped out of Coachella Valley, will be closed on both July 3 and Monday, July 6. This action is necessary in order to counter slow table grape sales activity during the week after Independence Day and recognize market closings in observance of the Independence Day holiday.

No action is necessary for table grape imports under section 608e–1 of the Act. A change in the import regulation (7 CFR 944–503) is applicable when there is a change in the grade, size, quality, and maturity of a domestically produced commodity. Therefore, since packing holiday regulations are not included in the requirements of section 8e, no change is necessary to the applicable import regulations.

A 10-day comment period is allowed to receive written comments with respect to this proposal. It is hereby found and determined that such a comment period is necessary, and all written comments timely received will be considered before a final determination is made on this matter. The California desert grape regulation is in effect, and this change, if adopted, should become effective as soon as possible.

List of Subjects in 7 CFR Part 925

Marketing agreements and orders, Grapes, California.

For the reasons set forth in the preamble, Part 925 is proposed to be amended as follows:

PART 925—GRAPES GROWN IN A DESIGNATED AREA OF SOUTHEASTERN CALIFORNA

1. The authority citation for 7 CFR Part 925 continues to read as follows:

Authority: Secs. 1–19, 48 Stat. 31, as amended; 7 U.S.C. 601–674.

2. Section 925.304, introductory text, is revised to read as follows:

§ 925.304 California desert grape regulation 6.

During the period April 20 through August 15 each year, no person shall pack or repack any variety of grapes except Emperor, Almeria, Calmeria, and Ribier varieties on any Saturday, Sunday, Memorial Day, or the observed Independence Day holiday, unless approved in accordance with paragraph (e) of this section, nor handle any variety of grapes except Emperior, Calmeria, Almeria, and Ribier varieties, unless such grapes meet the requirments specified in this section: *Provided,* That for the 1987 season, July 6, 1987, shall be substituted for July 3, 1987, as the Independence Day packing holiday.

* * * * *

Dated: June 8, 1987.

Ronald L. Cioffi,

Acting Deputy Director, Fruit and Vegetable Division, Agricultural Marketing Service.

[FR Doc. 87–13386 Filed 6–9–87; 8:45 am]

BILLING CODE 3410–02–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for Housing—Federal Housing Commissioner

24 CFR Parts 200, 203, 221, 222, 226, 234, and 235

[Docket No. R–87–1472;FR–2036]

Single Family Mortgage Insurance Programs; Criteria for Acceptability of Insured 10-Year Protection Plans

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Proposed Rule.

SUMMARY: This proposed rule would revise the existing administrative criteria for acceptability of insured 10-year protection Plans (Plans) for purposes of the Department's single family mortgage insurance programs. HUD acceptance of these Plans is a prerequisite to reduced inspection requirements on a property accepted for mortgage insurance before the commencement of construction. It is also a prerequisite to high loan-to-value insured financing for existing one- to four-family dwellings that are less than one year old and that were not approved before the start of construction and inspected by HUD or the Veterans Administration.

The Department began this proceeding by publishing a Notice informing the public that HUD intended to revise the criteria. This rule describes, among other things, criteria related to Plan acceptability, insurance and financial backing, Plan coverage, and methods for determining Plan obligations.

DATE: Comments must be received by August 10, 1987.

ADDRESS: Interested persons are invited to submit comments regarding this rule ot the Office of the General Counsel, Rules Docket Clerk, Room 10276, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington DC 20410. Communications should refer to the above docket number and title. A copy of each communication submitted will be available for public inspection and copying during regular business hours at the above address.

FOR FURTHER INFORMATION CONTACT: Morris E. Carter, Director, Single Family Development Division, Room 9270, 451 Seventh Street, SW, Washington DC 20410. Telephone number (202) 755–6720. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION:

Statutory Background

Section 310 of the Housing and Community Development Amendments of 1979 (Pub. L. 96–153) amended section 203 (b)(2) of the National Housing Act (NHA) to permit HUD to insure a mortgage with a higher loan-to-value ratio (*i.e.*, in excess of 90 percent of the appraised property value) for existing single family homes less than one year old, where the dwelling was not approved for mortgage insurance before the beginning of construction, provided that "(iii) the dwelling is covered by a consumer protection or warranty plan acceptable to the Secretary and satisfies all requirements which would have been applicable if such dwelling had been approved for mortgage insurance prior to the beginning of construction."

Statutory Implementation

The Department implemented this amendment in regulations at 24 CFR 203.18(a)(2)(iii) and in HUD Handbook 4145.1, *Architectural Processing and Inspections for Home Mortgage Insurance.* Paragraph 3-27b of the Handbook states that only the final inspection of a property is required (usually the property is inspected at three separate stages of construction) if the application designates a Plan covering the property that is acceptable to FHA.

The Notice of Solicitation of Public Comments

On November 14, 1984 (49 FR 45075), the Department published a Notice of Solicitation of Public Comments. That Notice proposed certain revised criteria that underwriters or insurers applying for HUD acceptance of a Plan would have to meet. The proposed criteria are as follows.

Among other things, an acceptable Plan had to protect the property owner for a period of 10 years. Also, the Plan had to be backed (1) by an underwriter that was able to meet specified minimum financial requirements and standards of industry rating, or (2) by a State that guaranteed the builder's performance and the State's continuing financial commitment, throughout the Plan's coverage period. The Notice also provided for HUD consideration of a Plan issuer that wished to act as a self-insurer. Additionally, the underwriter or insurance company backing a Plan had to be approved to do business in the State where the property is located. Finally, the coverage could not be cancellable by the underwriter, and the full cost of coverage had to be borne by the builder in a manner that would enable transferees of the property, as well as the original purchaser, to be covered without additional cost. Specifically, the Plan had to (1) warrant against all defects in workmanship and materials for one year following the commencement of coverage; (2) warrant against defects in the wiring, piping, and ductwork for the first two years of coverage; (3) directly insure against structural defects that seriously affect livability during the third through the tenth year of coverage; and (4) provide a system for handling complaints that includes conciliation and, if necessary, arbitration of disputes.

Summary of This Proposed Rule (Incorporating Revisions to the Notice)

The Department, after reconsideration, has determined that the criteria for a 10-year protection Plan are more appropriately the subject of a rule than of a Notice. Accordingly, after their publication as a final rule, these criteria will become part of the Department's regulations, codified in Title 24 of the Code of Federal Regulations (CFR). The Notice has now been revised substantively and restructured for issuance as this proposed rule.

Section 203.200, "Definitions", would define more terms than appeared in paragraph 8 of the Notice, *Definitions.* In addition to revising the definition of "coverage contract" and reissuing the Notice's definition of "structural defect", this proposed rule would define the terms "Plan", "unencumbered financial resources", "warranty company", "construction deficiences", "insurance backing", "multiple-line insurance company", "plumbing", "policy year", and "single-line insurance company". These definitions would be included to add clarity to the rule.

New § 203.201, "Scope", clarifies that this rule would apply to one- to four-family dwellings covered by HUD mortgage insurance (including family units in a condominium where the units are insured under 24 CFR Part 234, Subpart A.)

Section 203.202, captioned, "Plan acceptability and acceptance renewal criteria—general", would incorporate some of the provisions of paragraphs 1 and 7 of the Notice, *General Plan Acceptability Information* and *Requests For* homeowner's having to determine liability among the principals providing the coverage. To that end, this section would provide that if a builder fails to correct significant construction problems in a covered property, the Plan issuer must effect the corrections. Similarly, if a Plan issuer, for any reason, fails to effect the corrections, its insurance backer must do so.

Paragraph (b) of § 203.202 states that HUD would impose sanctions against a Plan issuer if HUD finds that the Plan issuer has failed to fulfill its obligations to the homeowner. Paragraph (c) details the requirements and procedures regarding Plan acceptance and acceptance renewal. Section 203.202(d) states that after a Plan has been accepted, HUD approval must be obtained for any Plan modification. Failure to receive this approval would be a cause for termination of a Plan's acceptance. Paragraph (e) gives the address of the HUD office responsible for determining the acceptability of Plans, along with advising applicants that accompanying their requests for Plan acceptance must be evidence of Plan compliance with certain regulatory requirements.

Section 203.203, "Issuance and nature of insured 10-year protection plans", which would incorporate part of paragraph 1 of the Notice, indicates who may issue a Plan and how a Plan must be structured.

Section 203.204, "Requirements and limitations of a plan", would include provisions from paragraphs 1 and 2 (General Plan Acceptability Criteria) of the Notice. This section would set out the additional requirements and limitations that a Plan must meet to be acceptable to HUD. The main purpose of these requirements, along with §§ 203.202 and 203.205 which are referenced under § 203.204, would be to ensure that a covered homeowner is properly protected under a Plan. For example, while recognizing that Plans invariably contain clauses that exclude coverage of certain conditions or events, the rule, nonetheless, would require that exclusions not result in the defeat of the coverage objectives stated in §§ 203.202 and 203.205. See § 203.204(e) of the proposed rule.

As a means of limiting the expense of a homeowner who is covered under a Plan, § 203.204 would provide that Plan coverage must be prepaid by the builder, and in the case of sale of a covered home, the coverage must be transferable without additional cost. Also, the coverage must be noncancellable, and there is a cap on the deductible payable by a homeowner making a claim. Further, so that a homeowner may have a ready source for determining his or her rights and duties and the extent of the Plan's coverage and obligations, proposed § 203.204 states that a Plan issuer must provide a homeowner with a copy of the coverage contract that clearly describes these and other provisions, including the availability of arbitration to settle disputes arising under the Plan.

Section 203.204 also would specify that an issuer will not be required to assure that a covered property complies with original dwelling plans and building codes. The rule does not propose to mandate compliance with plans and codes, since, as a practical matter, a Plan issuer, in its own self-interest, may be expected to require such compliance from the builder as a prerequisite to contracting for Plan coverage on homes constructed by the builder. Additionally, this section would require that, with respect to a condominium association, the deductible would be limited to $2500 per claim during the term of Plan coverage. (The allowable deductible is proposed to be higher for a condominium association than for a homeowner, because condominium claims could potentially be higher than claims filed on a single family dwelling.)

Section 203.205, "Plan coverage", is substantively similar to paragraph 3 of the Notice, *Plan Coverage Criteria.* This section would detail when coverage under a Plan must begin (the date of settlement), along with specifying the items that a Plan or builder must warrant and the duration of the warranty. The specificity here is intended to ensure that all parties to a covered dwelling are well aware of their rights, obligations, and responsibilities, to help avoid disputes that may delay addressing a homeowner's complaint.

Section 203.206, "Housing performance standards or criteria", is adpated from paragraph 3(d) in the Notice, *Plan Coverage Criteria.* The rule makes this paragraph a separate section to emphasize the importance that the Department attaches to a fair procedure for resolving claims made under a Plan.

Section 203.207, "Financial strength criteria", is essentially a new provision that would detail the criteria HUD would apply in evaluating the financial soundness of a Plan. These criteria emphasize industry rating of the insurance company backing a Plan and the amount of assets that must support a Plan. In selecting these criteria, HUD was mindful of the need to fix standards that would ensure that Plans had adequate resources or backing to cover their potential obligations but, at the same time, not set prohibitively high qualifying criteria.

Similarly, § 203.208, "Potential plan obligations", contains material not included in the previously published Notice. It is intended to give Plan issuers a systematic method of determining their obligations. (A table giving the multipliers to be used for computation of potential Plan obligations is appended to this section, along with sample computations of potential Plan obligations.)

Commenters and other interested parties are invited to examine the underwriting studies used to compile the Table. Examination will be by appointment, and the underwriting studies may be examined in Room 9272 of the Department of Housing and Urban Development at the address shown above. Interested parties should call (202) 755–6700 to arrange an appointment. (This is not a toll-free number.)

Section § 203.209, "Insurance backing criteria", is the counterpart of paragraph 4 of the Notice. Some of the more detailed financial requirements of paragraph 4 would be removed, however, in favor of criteria that would adopt industry ratings. In addition, the rule does not contain most of the provisions of paragraph 5, *Homeowner Information;* paragraph 6, *Annual Plan Certification;* and most of subparagraphs (a) through (k) of paragraph 7. The rule does not continue these provisions because the Department, on further consideration, now regards them as unduly

burdensome or unnecessary. (A full discussion of the Department's reasons for not continuing these provisions appears in the discussion of public comments.)

Public Comments

The Notice invited comment on the proposed revisions, and specifically sought information and comment on the proposed criteria for assurance of a Plan's financial responsibility.

Eighty-four comments were received on the Notice, 50 of which were reproductions of four separate letters. The 50 comments generally supported the rule Arguments raised in the other 34 comments are summarized here by the subject matter that they addressed, along with the Department's responses.

A. Insurance Backing Criteria

With respect to the "Insurance Backing Criteria" proposed in the Notice, a majority of commenters supported HUD's proposal to provide for a minimum financial size for an insurance company backing a Plan. Several commenters, however, questioned the wisdom of the provision, viewing it as being biased against small companies.

Specifically, the latter commenters argued that the Notice's proposed requirements governing financial size and policyholder surplus bore no relationship to the amount of business a company might generate and that the requirements might be excessive for some States. Moreover, once a company met the proposed minimum levels, it could write any amount of coverage in any number of States without being subject to proper capital requirements. One commenter urged that the emphasis should not be on the $12.5 million and $3.0 million minimums, but on how the minimums relate to several critical factors in the business of writing homeowner warranty plans—such as the number of policies written; the amount of the contingent liability involved (*i.e.*, the cost of properties covered); loss experience and the claims-handling efficiency of a company; the "tail" outstanding (*i.e.*, the number of years left in the warranty period covered by a Plan); and the nature and amount of other insurance business with which an insurer of a Plan is involved.

Another commenter expressed concern over the proposed requirement that any insurance company backing a warranty Plan must have a financial size equal to or larger than class XI (as rated by the A. M. Best Co.). The commenter believes it is a mistake to gauge an insurance company's financial security by financial size only, without reference to the adequacy of the net safety factor, including the adequacy of the claim reserves, the profit or loss from underwriting, or the soundness and liquidity of assets. The commenter concluded that the A. M. Best rating classifications reflect these evaluations (A+, A, B+, B, C+, C Omitted), and that these should be the criteria that HUD uses for qualifying insurance companies.

Another comment objected to the proposed $3 million surplus requirement as being anti-competitive and harmful to the public interest. This commenter saw the primary beneficiaries of this proposal being companies already in business. These established companies now have millions in capital and would be able to monopolize the industry, because the proposed requirement would prevent new companies from entering the industry, according to the commenter.

HUD agrees that the earlier proposal's treatment of capital requirements should be revised, and is here proposing alternatives preferred by a number of commenters. The proposed rule no longer would mandate minimum financial surplus requirements for an insurance company backing or directly writing a Plan. Instead, HUD would accept a Plan backed by an insurance company with a rating of A or better by the A.M. Best Company. An unrated multiple-line or single-line insurance company, or one rated less than A, must show that it has reinsurance equal to at least the amount of potential Plan obligations. As an alternative, a single-line insurance company would be acceptable if it could demonstrate that it owns unencumbered financial resources in excess of any retained risk. The excess must at least equal the amount of the potential Plan obligations, less the Plan's reinsurance coverage.

HUD believes that basing the Department's acceptance of a Plan on the rating assigned the Plan's insurance backer is a more appropriate means for determining the financial soundness of a Plan and its backer, and that the proposed rating system will reduce information collections required under the rule. Similarly, deemphasizing the financial size of the insurance company backing a Plan (the Notice required that the insurance backer be at least a Class XI, as shown by the A.M. Best Company) in favor of requiring a high industry rating for the Plan's insurance backer would eliminate any discriminatory treatment of Plans backed by small insurance companies. (HUD still proposes to accept Plans not rated by the A.M. Best Company, or those with a rating less than A, but only if their financial worth or their reinsurance is demonstrably adequate.)

In proposing adoption of the revisions described above, the Department has considered, but rejected, other revisions recommended in the comments. For example, one comment argued for the imposition of a minimum policy holder surplus of $1 million for each 10,000 homes in a Plan, with later adjustments to the surplus, based on the Plan's loss experience. The proposed rule does not incorporate this recommendation because, among other things, representative industry loss experience indicates that a $1 million minimum surplus would underfund reasonably expected losses for many Plans. Further, making the necessary adjustments under this suggested formula would require HUD's detiled checking of a company's records. The Department does not have the resources adequately to discharge such a task, nor does HUD believe that its auditing of an insurance company's records or operations is a proper burden for the Department to assume. HUD would not adopt other recommended formulae because they, too, would have required the Department to examine in detail a company's financial records and operations, creating unnecessary paperwork and administrative burdens on both the companies and the government.

B. Role of Insurance Companies

Comments on the insurance backing criteria also touched on the role of insurance companies in protection Plan, and what some commenters viewed as HUD's attempt to regulate these companies.

As a general response, HUD has no intention of regulating insurance companies. The Department recognizes that these companies are regulated by the State—not by the Federal government. Insofar as this rule is concerned, HUD would accept insurance backing of Plans where an insurer's resources are shown to meet HUD's criteria for acceptability, *and* the insurer is duly authorized to write dwelling performance coverage in each State in which HUD acceptance of a Plan may be sought. If a Plan's insurer is not authorized to do business in a State, HUD would not accept the Plan's housing warranty coverage in the State.

The rule's position is analagous to HUD's relationship with banking and thrift institutions: HUD regulates neither, but accepts individual banks and thrift organizations as mortgage lenders, provided they comply with certain HUD-imposed requirements.

Only this type of relationship is envisioned by the establishment of HUD criteria for acceptability of insurance backing of housing performance warranties.

A commenter stated that State insurance commissions currently collect financial information from insurance companies licensed and operating in their States, and that HUD's request for this information is unnecessary, since the information is already on file with State commissions.

A company could usually meet the proposed rule's information requirements by giviung HUD copies of the same information that it provides the insurance commission in each State in which it operates. HUD needs this information because State insurance requirements vary, and are generally limited to a particular State's concerns. HUD's concern, however, would be with a company's multi-State operations—a company's compliance with individual State requirements provides only a limited view of its overall financial condition. To ensure that an insurance company can meet its obligations under a Plan which is offered in several States, HUD must evaluate the insurance company's multi-State operations.

To commenters objected to the requirement in the Notice that an insurance company backing a Plan must be a property and casualty insurance company. They view the requirement as conflicting with State law and case law. The requirement has been removed as unnecessary restrictive.

The Notice was criticized for alleged unfairness because it would allow risk retention companies (which, a comment claimed, are subject to State law) to write unlimited insurance in a State and not maintain the same minimum net worth and reserves required of an insurance company registered in the same State. The commenter is partly in error with respect to its claim that risk retention companies are not subject to State law. Under the Product Liability Risk Retention Act, 15 U.S.C. 3902, a risk retention group must comply with certain insurance requirements of each State in which it is doing business, in addition to having its operation regulated by its chartering State. In any event, the criteria set out in this rule would apply uniformly to Plans offered by risk retention groups, as well as to Plans offered directly by insurance companies, or by builders and warrantors with insurance backing. In all cases, applicable State insurance regulatory requirements would have to be met as a prerequisite for HUD acceptance of Plans. Any advantage enjoyed by risk retention companies would arise out of the statute that the Congress enacted for the regulation of these companies. This rule would not independently afford risk retention companies an unfair advantage over insurance companies.

A commenter objected to the provision that required a Plan to be so structured that its reinsurer's ultimate responsibility for effecting corrections would be included in the Plan. According to the comment, the reinsurer's responsibility will be enforced by the governing State insurance commission.

Because of the differences in State insurance laws, HUD cannot be assured that each State's law will find ultimate legal responsibility under a Plan, such as is envisioned under this rule. Therefore, the rule proposes that a Plan must provide that the plan's insurer(s) or reinsurer(s) bear the ultimate liability for correction of construction deficiencies when a builder, another warrantor, or another insurer fails to discharge this responsibility.

The suggestion was made that HUD consider approving certain 10-year Plans under which builders of some predetermined net worth elect to self-insure or to bond to certain required limits (the limits to be set by HUD) in the event of their financial inability to perform. HUD has examined alternatives whereby a builder might self-insure housing performance coverages, but has identified no acceptable alternative to insured 10-year protection Plans. Assured performance backing must be available if a builder fails to perform in accordance with required coverage provisions. Such backing is intentionally much broader than backing that is available only if the builder were financially unable to perform. The Department has identified no surety that would obligate itself for such broad backing, that is structured to provide the range of services such backing might require, and that would make the necessary corrections to a home or facilitate the settlement of claims without first subjecting these claims to litigation. For these reasons, surety bonds are not considered an acceptable alternative to the ready availability of financial resources or insurance backing, as would be required by this rule.

A commenter recommended that to ensure that Plans are backed by financially responsible companies, HUD should clarify its requirement that builders and warranty companies have "full backing" by insurance. This is potentially confusing, said the comment, because some States require that warranty companies be backed to some extent by insurance. Thus, the proposed requirement might be construed as equating compliance with State law concerning the obtaining of a surety bond by warranty companies with "full backing * * * by one or more insurance companies." The clarification should indicate, the comment continued, that "full backing etc." means obtaining insurance in an amount adequate to ensure the performance by a warranty company of its obligations on all of its outstanding warranties (*i.e.*, an amount equal to the purchase price of the properties covered by the warranties), regardless of whether State law permits the warranty company to insure at some lower level.

The proposed rule would remove the ambiguity pointed out by the commenter by specifying that "Plans may be issued: (1) By a builder * * * with insurance backing of Plan performance." The new language clarifies that a plan must not only have insurance backing, but also that the insurance must specifically back the Plan's performance, *i.e.*, the obligations that the Plan issuer has assumed. The Department declines to follow the commenter's suggested definition of "full backing". The amount of insurance required under this definition would be excessive. Moreover, it is unlikely that any insurance company—even if it possessed the tremendous financial resources required to qualify under the suggested definition—would be interested in backing a Plan so structured. The Department further notes that, beyond the fact that such a requirement seems inconsistent with accepted insurance principles, experience with these Plans does not indicate that, realistically, a Plan's liability would even approach an amount equal to the purchase price of all the properties covered by the Plan.

One contention raised was that the delays inherent in securing Plan revision approval on a State-by-State basis discriminate against the multi-State Plan providers now in good standing vis-a-vis those companies operating under the Product Liability Risk Retention Act. The rule's proposal for preapproval of any intended change to a Plan is not viewed by the Department as discriminating in favor of risk retention groups, but as protective of homeowners' rights under a Plan. HUD wants to be assured that changes in a Plan do not abrogate a homeowner's rights. As pointed out above, under 15 U.S.C. 3902, risk retention groups are subject to certain insurance laws of each State in which they operate.

Therefore, to the extent that a State requires insurance companies, as well as risk retention groups, to file for approval of changes in their coverage or in operations generally, then these groups are treated no differently than under the Plans. Moreover, the Department has no authority under the Product Liability Risk Retention Act to impose requirements on risk retention groups not authorized by the Act.

C. Acceptability and Certification of Plans.

A commenter suggested that, in the interest of fairness, there should be a "grandfathering" of Plans in good standing. No grandfathering of existing Plans is contemplated. However, the Department proposes in the rule to allow existing Plans a grace period of up to 6 months after the effecive date of HUD's final rule, during which these Plan issuers could make the necessary adjustments to comply with the new provisions. (See proposed § 203.202(f).)

A commenter found the requirement for HUD approval of Plan changes objectionable. The requirement, the commenter said, is potentially burdensome with respect to inconsequential changes that must often be made to comply with State insurance departments' demands that in turn are a precondition to receiving approval for a Plan. The commenter concluded that, since State approval of the insurer of a Plan is a prerequisite to HUD acceptance, such changes to the HUD-accepted Plan should be allowed, without further HUD approval, if they are required by a State insurance department.

The Department is unsure as to what changes the comment would consider "inconsequential". HUD usually responds to inquiries about a Plan within 30 days of their receipt (typically within 14 days), so no undue delay is expected. Further, even if an insurer were to file a change to a Plan that is accepted by a State insurance commission, it does not follow that HUD would find the change acceptable. A State insurance commission's interest is in ensuring compliance by insurance companies with State law requirements governing these companies' operations. HUD's concern in proposed paragraph (d) of § 203.202 is not with an insurer *per se*, but with changes to a Plan backed by an insurer. These changes may have nothing to do with statutory requirements (and therefore might be of little interest to a State insurannce commission), but may affect a homeowner's rights secured by this rule. For this reason, the rule would mandate that changes in a Plan or its insurance contract be approved in advance by HUD.

Because of the complexity and length of insurance and reinsurance contracts, and so as not to burden unduly HUD staff, a commenter suggested that Plan issuers should be required only to provide certification of the existence of a valid and binding commitment of insurance or reinsurance placed with named insurer(s) and reinsurer(s), outlining the amount and term of each layer of coverage. This should be accompanied by a legal opinion stating that such commitments are in existence and enforceable in accordance with their terms. The requirement should pose no hardship for a Plan issuer, the commenter asserted, since all insurance binders are reviewed by an attorney. The proposed rule would require a summary from each insurer or reinsurer describing the nature of its commitment and the amount to which it is committed under its contract with a Plan to meet the Plan's obligations. HUD, however, reserves the right to examine fully all documents relating to a Plan.

A commenter recommended that provision be made for insurers to notify HUD of builders who fail to perform. Such builders should be denied further participation in HUD programs until they have been cleared by their insurer, argued the commenter. The rule makes no specific provision for notification to HUD by insurers of non-performing builders, but nothing in the rule precludes it. To the extent that builders fail to perform under their warranty or Plan, HUD may take action against them in accordance with 24 CFR Part 24, and impose sanctions as provided in that Part.

In the opinion of one commenter, if the documentation required for HUD acceptance of Plans may not be required of a Plan backed by the full faith and credit of a State, then the same documentation should not be required of the insurer of a "pure" insurance Plan, where the Plan is regulated by a State that protects the insured under a State guaranty fund. If the proposed rule's coverage criteria ar met (see § 203.205), HUD would accept a State-operated Plan backed by the full faith and credit of the State. HUD does not, however, have the resources to evaluate the finances and operation of individual State insurance guaranty funds. The operation and practices of such funds vary, and in some instances the funds have proved of uncertain value. Accordingly, HUD does not equate the financial backing available under a State guaranty fund with full and direct State financial backing.

A commenter complained that requiring a Plan to apply for acceptance renewal every two years is an unnecessary and excessive administrative requirement that would generate volumes of paperwork. Instead, insurance companies should be required to submit their annual financial report (which is required by all States), along with copies of all insurance documents on an annual basis. These could be reviewed to ensure that there has been no change in the financial stability of the Plan, according to the comment. In HUD's view, the submissions that the commenter suggests be made annually are essentially the same as HUD would require to be made only biennially. If the commenter's suggestion were followed, it would nearly double the amount of applicant and HUD effort involved in an acceptance renewal. HUD does not consider this a satisfactory result.

A commenter agreed that it may be somewhat justifiable to implement the requirements of paragraph 7 of the Notice for initial acceptance of Plans, but asserted that to impose these administrative requirements for *renewal* of acceptance of a Plan is unnecessary overregulation, and "surely must violate the intent and the provisions of the Paperwork Reduction Act of 1980." The commenter continued that only a small percentage of the homes insured by most Plans will be FHA-insured homes, but this requirement will ensure that the greatest percentage of paperwork and administrative cost will go toward acceptance, of renewal or acceptance, of a Plan by HUD. The proposed rule would no longer provide for the extensive submissions set forth in paragraph 7 of the Notice. The rule states that "Requests (for acceptance or renewal of or renewal of acceptance) must be accompanied by information and documentation evidencing Plan compliance with § 203.204." (See proposed § 203.202(e).) It would be the Plan's responsibility to submit documentation that would demonstrate conclusively its compliance with all relevant criteria. HUD review of a complete submission would be brief and timely, but HUD would not extend the expiration date of a prior Plan acceptance if the Plan provided incomplete information with its renewal application.

The earlier proposed Plan acceptance period of two years with automatic expiration if there is no renewal application from the Plan, might be less harsh, a commenter said if some grace period could be provided as well as notification from HUD with respect to the termination. The Department

declines to accept the further administrative burden of informing Plan issuers of the imminent expiration of their Plans' acceptance since the expiration date will be well-known to each Plan issuer.

A commenter suggested that in order to permit Plan issuers to respond quickly to changes in market conditions or to implement minor changes with a minimum of administrative burden, HUD should consider (1) requring Plan issuers to submit, with any proposed change or modification, a one-page summary that describes the nature of the change or modification, and (2) permitting Plan modifications or changes to become effective 30 days after their submission, unless HUD notifies the Plan issuer that the modification or change is rejected or requires further review. In our view, a requirement that a Plan issuer provide a summary of proposed changes in a Plan would add to the Plan issuer's and HUD's paperwork burden. Regardless of what a summary might state, it will likely be necessary for HUD to examine the details of proposed changes to determine their acceptability. Since HUD expects to respond to inquiries within 30 days, a Plan can reasonably anticipate that HUD will either accept a proposed change within that period or notify the Plan issuer that further review or discussion is necessary. For these reasons, the Department is not following the commenter's suggestion in the proposed rule.

The suggestion was made that in light of the prior approval requirement for all modifications, HUD should consider extending to three years the period that Plan approval is effective. In adopting a three-year acceptance period, HUD could provide that issuers would have to respond to specific HUD requests for information during the period, and would have to submit any additional information that is required of issuers as a result of any amendment of the Plan criteria by HUD. This one-year extension of the acceptance period would significantly reduce expenses and administrative work for both HUD and the Plan issuer, according to the comment, but would not reduce materially HUD's ability to monitor Plans. HUD has considered the comparative advantages of annual, biennial, triennial, and quadrennial Plan acceptance periods, and has decided to propose a biennial period. It offers the necessary balance, in the Department's view, between HUD's responsibility to evaluate periodically a Plan's operation and the administrative burden of imposing too-frequent filing requirements.

Another comment recommended that HUD include, in its final criteria, a description or "Checklist" of the factors that will be considered when the Department assesses a renewal application (e.g., performance of the issuer under the existing Plan). Also, the final criteria should clarify that if an existing Plan issuer submits a renewal application at least two months before its Plan expiration date, the Plan may continue in operation after its original termination date, unless HUD notifies the Plan issuer otherwise. The commenter asserted that such a provision is crucial to ensuring that the continuity of a Plan's operation is not adversely affected by delays in obtaining renewal approval. As indicated earlier, it would be the responsibility of a Plan to submit the necessary documentation to evidence compliance with the acceptability criteria set forth in this rule. These criteria will serve as the "checklist" that the commenter recommends. To restate the checklist would be largely redundant, in the Department's judgment. However, the rule proposes that if a renewal acceptability determination will be delayed past the expiration date of the prior Plan acceptance, and the delay is occasioned by HUD's failure to respond to the application in a timely manner, the expiration date will be extended by the duration of the delay. (See proposed § 203.202(c).)

D. Miscellaneous.

A commenter observed that the standard first-year warranties currently track the language, "The inability or unwillingness of the builders to so correct." The rule's proposed triggering language, "if a builder for *any reason* fails to correct them" appears to the commenter to be very broad and lacking in conditions or guidelines. It is HUD's intention that a responsible third party would assume a builder's obligations when a builder, for any reason, fails to correct in a timely manner a problem for which the builder is responsible. The cause of the builder's default may be bankruptcy, procrastination, uncertainty, refusal to perform, or any other reason. HUD's objective is to ensure that the builder's obligations will be discharged, if necessary, by a responsible third party. The language is deliberately broad, and would admit of no condition to ensure that correction of a homeowner's problems would not be unduly delayed because of a problem associated with the builder.

HUD does not agree that the breadth of the language would be cause for "future definitional revision", as the commenter suggests. The language is written unconditionally in order to defeat a builder's or Plan's attempt to use frivolous reasons not to correct a covered problem. By the same token, frivolous complaints by a homeowner (which may be unavoidable) may not require a Plan issuer to respond.

The Department considered providing a list of qualifying reasons, but the uncertainty of enumerating an inclusive and exhaustive listing of all possible reasons militated against including a list in the rule. Where a "rule of reason" cannot resolve disputes between a homeowner and a builder or Plan, conciliation or arbitration, as provided for in § 203.204(g), is an available recourse to settle disputes.

One comment suggested that each Plan should contain guidelines defining what is considered by the industry to be (1) "structural damage" and (2) what is required to be repaired. Without these guidelines, the commenter contended, the Plan could create misunderstanding, possibly leading to legal action. (There are industry guidelines for plumb, level, width of a crack, and offsets so that stress cracks or drying cracks are not misinterpreted as structural failure, according to the comment.) The comment added that if a Plan does not include these criteria, interpretation and implementation of "repair" is never clear, and often is left to loss control adjustors who may be biased—resulting in consumers' not knowing the extent of their coverage, if any. This results, concluded the commenter, in a lack of credibility for the industry in general, and loes not provide homeowners with a clear understanding and comfortable feeling that they have been provided the warranty program that they thought they were receiving.

While the rule does not define "structural damage", it does define "structural defect". See § 203.250. "Damage" is not defined because, in HUD's view, its determination is less controversial, since it is usually patent or caused by a readily identifiable act. Also, the rule does not itemize what "is required to be repaired", relying instead on the broadly stated guidelines in § 203.205. The Department declined providing an itemized list of what problems must be repaired because of the lack of uniform standards or guidelines for acceptable housing performance and because of the difficulty of formulating an exhaustive list of repairable items. In this regard, the Department is mindul too that the

formulation of comprehensive guidelines has eluded the building industry and professions associated with it because of the effects of combinations of problems and different environmental conditions. It should be noted, however, that to the extent § 203.205 mandates Plan coverage of certain kinds of property or construction defects, the Plan issuer is bound to repair them.

The Department also notes that the issue of what a Plan issuer may repair, as raised by the comment, is fairly well settled insofar as all Plans specify what housing performance is covered, and most Plans specify what they consider to be performance deficiencies, including methods for correcting them. To the extent that a Plan stipulates criteria and standards for evaluating defects and their corrections, HUD will require that they be acceptable to the Secretary as reasonable, fair, and fully consistent with the intent of required coverages, but HUD does not specify their content. See § 203.206.

The Department agrees with the comment that it should not be the responsibility of the warranty company to ensure that written manufacturers' warranties for appliances and equipment are delivered to homeowners. The rule no longer would provide that Plan issuers deliver manufacturers' warranties to homeowners. This action is normally taken by the builder in the course of delivering a new home. However, in the event of a problem involving faulty installation of, or builder damage to, an item warranted by a manufacturer, Plans must provide for payment of corrections, if the builder fails to do so.

A commenter contended that non-loadbearing basement slabs should not be included in the definition of "Structural Defect". In states like Colorado, where basement construction is a marketing necessity and expansive soils are the norm, insuring non-loadbearing basement slabs for a period of 10 years against defects and failures that may be construed as affecting the livability of a property could price home warranties beyond the reach of both homeowners and builders, the comment claimed. Moreover, the inclusion of non-loadbearing slabs in the definition may create a belief that builders are responsible for repairs regardless of causation.

In the Department's judgment, where cement concrete floor slabs are not attached to other elements of dwelling foundations and are intended to "float", they should have sufficient inherent structural integrity to float as a unit without breakage or excessive deflection that would impair their function as a floor, or the performance of other dwelling elements. Floating floors should be designed and constructed to resist damage from foreseeable, potential differential movements of supporting soils or other building elements. Where potential differential movements may be significant, the potential problem is foreseeable and damage avoidance is practical. Floor damage can adversely affect utility and livability, and must be covered when it is significant. Accordingly, the Department has not followed the commenter's suggestion.

On the question of deductibles under a Plan, it was argued that because (1) the National Housing Act requires only one year of builder-provided warranty; (2) HUD has approved Plans under which the builder provided direct coverage for only one year; and (3) a two-year aggregate deductible could significantly increase costs to insurers that provide direct coverage beginning in the second year of a Plan, HUD's limitation on aggregate deductibles should be applied only during the first year of a Plan (or only so long as the builder provides direct coverage under a Plan). Alternatively, HUD should adopt an intermediate limitation on deductibles in the second year of a Plan by imposing a $100 per-claim cap on deductibles in that year.

The Department does not agree that the commenter's reasons support the conclusion that HUD's limitation on aggregate deductibles should be applied only during the first year of a Plan. The rule would provide for a maximum deductible of $250 per claim during the third through the tenth year of Plan coverage, and a limit of $250 in deductibles during the first two years of coverage. In the case of a condominium association, the deductible would be limited to $2,500 per claim.

Since these Plans should be protective of homeowners, HUD believes that a homeowner's out-of-pocket expenses (*i.e.*, payment of deductibles) should be limited to the extent possible. Further, because builder and manufacturer warranties usually cover potential first-year problems, the homeowner may not have to pay deductible in the first year. Stated differently, the Plan may not have to effect corrections in the first year because of these existing warranties, and therefore no deductible would be paid. (HUD's position assumes, admittedly, that in the first year both builder and manufacturer will honor their warranties.) Both homeowner and Plan exposure increases as of the second year (*i.e.*, builder and manufacturer warranties would have expired after the first year and the Plan would then be liable for covered repairs—in which case the homeowner would be faced with paying a deductible—limited to a maximum of $250 for all claims filed by the second year). Accordingly, it is HUD's intention that as between Plan and homeowner, the homeowner be protected insofar as the cost of corrections is concerned by imposing a two-year aggregate deductible of $250 during years one and two of Plan coverage.

In this connection, it should be noted that not all Plans provide for homeowner payment of a deductible. While these Plans may be in the minority, it suggests that some Plans—contrary to the commenters's apprehensions—do not consider the imposition of a deductible to be a necessary cost containment measure.

The National Academy of Conciliators (NAC) petitioned for its inclusion (along with the American Arbitration Association (AAA)) as an acceptable entity for the resolution of disputes regarding homeoners' complaints. According to the NAC, it has handled over 20,000 cases for the HOW program, and is considered, perhaps, the most experienced organization in the area of adjudicating builder/buyer disputes.

The rule would not include the NAC as a possible source for the resolution of disputes, but HUD does not discourage NAC involvement in the conciliation process. Homeowners and Plans may voluntarily elect to involve the NAC in the dispute settlement process. The rule, however, does propose to sanction AAA involvement. Because AAA membership is drawn from different backgrounds, whereas NAC membership is disproportionately drawn from the building industry, homeowners, HUD belives, may more readily accept an AAA award.

Findings and Certifications

A Finding of No Significant Impact with respect to the environment has been made in accordance with HUD regulations at 24 CFR Part 50, which implement section 102(2)(C) of the National Environmental Policy Act of 1969. The Finding of No Significant Impact in available for public inspection during regular business hours in the Office of the Rules Docket Clerk, Office of the General Counsel, Department of Housing and Urban Development, Room 10276, 451 Seventh Street, SW., Washington, DC 20410.

This rule would not constitute a "major rule" as that term is defined in section (1)(d) of the Executive Order on Federal Regulations issued by the President on February 17, 1981. An

analysis of the rule indicates that it would not (1) have an annual effect on the economy of $100 million or more; (2) cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or (3) have a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In accordance with 5 U.S.C. 605(b) (the Regulatory Flexibility Act), the Undersigned hereby certifies that this rule would not have significant economic impact on a substantial number of small entities. The rule would protect homeowners who receive Plan coverage that guarantees correction of construction problems, but it would impose no financial requirement that qualified and reputable Plan provides are not already meeting.

This rule was listed as item number 925 in the Department's Semiannual Agenda of Regulations published on April 27, 1987 (52 FR 14362) under Executive Order 12291 and the Regulatory Flexibility Act.

The Catalog of Federal Domestic Assistance program numbers are 14.108, 14.117, 14.120, 14.133, 14.146, 14.165, 14.166.

The information collection requirements contained in this rule have been submitted to the Office of Management and Budget for review under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C 3501–3520). The OMB control number, when assigned, will be announced in the **Federal Register.**

List of Subjects

24 CFR Part 200

Administrative practice and procedure, Claims, Equal employment opportunity, Fair housing, Housing standard, Loan programs: Housing and community development, Mortgage insurance, Organization and functions (Government agencies), Reporting and recordkeeping requirements, Minimum property standards, Incorporation by reference.

24 CFR Part 203

Home improvement, Loan programs: Housing and community development, Mortgage insurance, Solar energy.

24 CFR Part 221

Condominiums, Low and moderate income housing, Mortgage insurance, Displaced families, Single family housing, Projects; Cooperatives.

24 CFR Part 222

Condominiums, Military personnel, Mortgage insurance.

24 CFR Part 226

Government employees; Mortgage insurance, Single family housing.

24 CFR Part 234

Condominiums, Mortgage insurance, Homeownership, Projects, Unit.

24 CFR Part 235

Condominiums, Cooperative, Low and moderate income housing, Mortgage insurance, Homeownership, Grant programs: Housing and community development.

Accordingly, the Department would amend 24 CFR Parts 200, 203, 221, 222, 226, 234, and 235 as follows:

PART 200—INTRODUCTION

1. The authority citation for Part 200 would continue to read as follows:

Authority: Secs. 2, 211, and 807, National Housing Act (12 U.S.C. 1703, 1715b and 1748f); sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C 3535(d)); Subpart G is also issued under sec. 214. Housing and Community Development Act of 1980, as amended by sec., 329, Housing and Community Development Amendments of 1981 (42 U.S.C. 1436a).

2. In § 200.163, paragraph (b)(5)(x) would be revised to read as follows:

§ 200.163 Direct endorsement.

* * * * *

(b) * * *

(5) * * *

(x) For proposed construction, where the mortgagee does not obtain a VA CRV, VA MCRV, HUD conditional commitment, HUD master conditional commitment, or a consumer protection or warranty plan or submit the plans and specifications for HUD's prior approval, a certification by a HUD-approved architect, engineer or construction analyst that the plans and specifications comply with the applicable property standards. After January 11, 1988, if the mortgagee obtains a consumer protection or warranty plan, the Plan must meet the requirements of §§ 203.200–203.209 of this chapter.

* * * * *

3. § 200.164, paragraph (d) would be revised to read as follows:

§ 200.164 Approval of direct endorsement mortgagees.

* * * * *

(d) To be approved for participation in the Direct Endorsement program, the mortgagee must have on its permanent staff an underwriter approved by the Department for participation in the program and authorized by the mortgagee to bind it on matters involving the origination of mortgage loans under the program. The technical staff that the mortgagee uses in the Direct Endorsement program (including appraisers, construction analysts, inspectors, mortgage credit examiners, architects, and engineers) must also be approved by the Department. The technical staff may be employees of the mortgagee or may be hired on a fee basis from a HUD panel. A mortgagee that has a financial interest in, owns, is owned by, or is affiliated with a building/selling entity, may originate and process mortgages for this entity under the Direct Endorsement program, only if the property appraisals and inspections are done by independent appraisers and inspectors approved and assigned by the Department, rather than by appraisers or inspectors on the staff of the mortgagee. For proposed construction, where the mortgagee does not obtain a VA CRV, VA MCRV, HUD conditional commitment, or HUD master conditional commitment, or a consumer protection or warranty plan, or submit the plans and specifications for HUD's prior approval, the mortgagee must use an HUD-approved architect, engineer, or construction analyst to certify that the plans and specifications meet the applicable standards. After January 11, 1988, if the mortgagee obtains a warranty plan, the Plan must meet the requirements of §§ 203.200–203.209 of this chapter.

* * * * *

PART 203—MUTUAL MORTGAGEE INSURANCE AND REHABILITATION LOANS

4. The authority citation for Part 203 would continue to read as follows:

Authority: Secs. 203, 211, National Housing Act (12 U.S.C. 1709, 1715b); sec. 7(d), Department of Housing and Urban Development Act 42 U.S.C. 3535(d)). In addition, Subpart C also is issued under sec. 230, National Housing Act (12 U.S.C 1715u).

5. In § 203.18, paragraph (a)(2)(iii) would be revised to read as follows:

§ 203.18 Maximum mortgage amounts.

(a) * * *

(2) * * *

(iii) Is covered by a consumer protection or warranty plan acceptable to the Secretary and satisfies all requirements that would have been

applicable if such dwelling had been approved for mortgage insurance before the beginning of construction. After January 11, 1988, any consumer protection or warranty plan must meet the requirements of §§ 203.200–203.209.

* * * * *

6. In § 203.46, paragraph (e)(3) would be revised to read as follows:

§ 203.46 Eligibility of modified graduated payment mortgages.

* * * * *

(e) * * *

(3) Is covered by a consumer protection or warranty plan acceptable to the Secretary and satisfies all requirements that would have been applicable if such dwelling had been approved for mortgage insurance before the beginning of construction. After January 11, 1988, any consumer protection or warranty plan must meet the requirements of §§ 203.200–203.209.

* * * * *

7. Part 203 would be amended by adding a new undesignated center heading and by adding new §§ 203.200 through 203.209, to read as follows:

Insured Ten-Year Protection Plans (Plan)

§ 203.200 Definitions.

As used in § 203.201 through § 203.209, the following terms shall have the meaning indicated:

"Coverage contract" means a warranty certificate, insurance policy, or other document of similar purpose (including any endorsements), delivered to the homeowner at the time of closing, which is issued by a builder, warranty company, or insurance company and which defines the terms and conditions under which a Plan will provide warranty coverage of the covered property.

"Construction deficiencies" are defects (not of a structural nature) in a dwelling covered by an insured ten-year protection plan that are attributable to poor workmanship or to the use of inferior materials, or that result in the impaired functioning or unsightliness of the dwelling or some part thereof. Defects resulting from homeowner abuse or from normal wear and tear are not considered construction deficiencies.

"Insurance backing" means the direct insurance or reinsurance of potential Plan obligations by one or more insurance companies.

"Insured ten-year protection plan" and "Plan" mean an agreement between a homeowner and a Plan issuer which, among other things, contains warranties regarding the construction and structural integrity of the homeowner's one- to four-family dwelling covered by an FHA-insured mortgage. A Plan may be issued by an insurance company, a warranty company, a risk retention group as defined in 15 U.S.C. 3901(4)(A)–(H), a builder, or by any other HUD-approved entity with the required insurance and financial backing. A Plan must specify in its coverage contract the obligations and duties of the Plan issuer to the homeowner (or to the homeowner's successor in interest) with respect to the warranties covering the dwelling.

"Multiple-line insurance company" means an insurance company that offers insurance coverage in addition to the insurance of Plans.

"Plumbing" means all components of piped on-site gas, fluid, or fluid-based systems that are not separately covered by manufacturers' warranties, and includes any on-site water supply or sewage disposal systems.

"Policy year" means a one-year accounting period established by a Plan issuer, which may or may not coincide with a calendar year, and which provides a base period for evaluating long-term experience with business originated during the accounting period.

A "risk retention group" is a corporation which is organized for the primary purpose of assuming and spreading all, or any portion, of the product liability or completed operations liability risk exposure of its group members, and which is chartered or licensed as an insurance company and authorized to engage in the business of insurance under the law of any State.

"Single-line insurance company" means an insurance company that only offers insurance backing of a Plan.

"Structural defect" means a failure, fracture, or excessive deflection of one or more load-bearing elements of a structure, which is of such a nature as seriously to affect the safey or livability of a property or the health of its occupants, including defects that occur in non-loadbearing basement floor slabs. A structural defect may be caused by faulty or deficient design, workmanship, materials, or construction, or by on-site conditions (or by a combination of these factors) that adversely affect the as-built structure. The term excludes damage caused by fire, flood, earthquake, tornado, and other perils usually covered by a homeowner's casualty insurance policy.

"Unencumbered financial resources" means assets that are readily available to satisfy and debt or obligation for which a Plan issuer or its insurance backer may be liable and that are not pledged or used as collateral for any other purpose.

"Warranty company" is an insurance company or other entity that provides insurance backing for an insured ten-year protection plan which, if the Plan issuer fails to meet its obligations to a covered homeowner, will assume the obligations and perform in accordance with the Plan's coverage contract with the homeowner.

§ 203.201 Scope.

The provisions and requirements set forth in § 203.202 through §203.209 apply to one- to four-family dwellings covered by HUD mortgage insurance (including family units in a condominium where the units are insured under Subpart A of Part 234 of this chapter).

§ 203.202 Plan acceptability and acceptance renewal criteria—general.

(a) For a Plan to be acceptable to HUD, it must assure that:

(1) If a builder, for any reason, fails to correct structural defects or significant construction deficiencies in a property covered by an insured 10-year protection Plan during the term of any warranty offered by the builder on the property, the Plan issuer will effect the corrections in accordance with the terms of the coverage contract; and

(2) If a Plan issuer, for any reason, fails to effect correction of these deficiencies or defects, or otherwise fails to honor the terms of its coverage, its insurance backer will effect the corrections or otherwise honor the terms of the Plan.

(b) In evaluating applications for renewal of Plan acceptance, HUD will take into consideration such reliable evidence as is made available to the Department of a Plan issuer's failure to fulfill its obligations. Where HUD has credible evidence of a Plan issuer's failure to correct covered homeowner problems, or there are justifiable homeowner complaints about untimely problem resolution by a Plan issuer, HUD will consider this as cause for termination of a Plan's acceptance and as grounds for initiation of sanctions against a Plan issuer or insurer in accordance with 24 CFR Part 24. If HUD proposes to terminate a Plan's acceptance, the issuer of the Plan will be advised of the reason therefore, and the procedural safeguards of Part 24 will apply.

(c) Unless renewed, Plan acceptance by HUD expires automatically on the second anniversary date of acceptance. The Plan issuer must apply for acceptance renewal at least two months, but no more than three months, in

advance of expiration to avoid automatic acceptance termination. Prior acceptance of a Plan will be continued beyond the date of automatic acceptance termination only by a written notification to the Plan issuer and only if the delay is cause by a lack of timely HUD processing of a renewal application. HUD will not extend the expiration date of a prior Plan acceptance if the Plan issuer has provided incomplete information with its renewal application.

(d) After a Plan has been accepted by HUD, there shall be no change in, or modification to, its provisions or in its insurer(s) or insurance contract(s), without prior written HUD acceptance of such change or modification. A violation of this condition may be cause for termination of a Plan's acceptance, and may be grounds for initiation of sanctions against the Plan proprietor in accordance with 24 CFR Part 24. Insofar as practicable, HUD will respond to a Plan issuer's request for acceptance of a change within 30 days of receipt of the request. Plan acceptance by HUD will be for a two-year period.

(e) Requests for initial HUD acceptance or renewal of acceptance of a Plan should be made to the Deputy Assistant Secretary for Single Family Housing, Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410. Requests must be accompanied by information and documentation evidencing Plan compliance with § 203.204. Acceptability of Plans will be determined by the Deputy Assistant Secretary for Single Family Housing who will notify applicants of the Department's determination. If a Plan is rejected, the applicant will be advised of the reason for rejection. Each HUD field office will be advised of Plans determined to be acceptable.

(f) Existing Plans will be allowed a grace period of 6 months (the period to commence from the effective date of the final rule) to make the necessary adjustments to comply with the provisions and requirements of § 203.200 to § 203.209.

§ 203.203 Issuance and nature of insured 10-year protection plans.

(a) Plans may be issued—

(1) By a builder, warranty company, insurance company, or risk retention group (see 15 U.S.C. 3901(4) (A)–(H), with insurance backing of Plan performance; or

(2) By a State that guarantees the builder's performance and the State's continuing financial backing throughout the Plan's coverage period.

(b) All Plans must have insurance backing unless backed by the full faith and credit of a State.

(c)(1) Plans backed by the full faith and credit of a State must be in compliance with §203.200 through § 203.202, and § 203.204 through 203.206 to be acceptable to HUD. HUD will evaluate these Plans to ensure their compliance with these sections.

(2) HUD will not accept Plans backed by a State agency or a State insurance guaranty fund unless HUD is assured that the full faith and credit of the State is pledged to satisfy any and all obligations of the state agency or guaranty fund that may arise in connection with its financial backing of a Plan.

(d) The functions of a warrantor and an insurance backer may be performed by a single corporate entity.

§ 203.204 Requirements and limitations of a Plan.

In addition to complying with the criteria set out in § 203.202 and § 203.205, for a Plan to be acceptable to HUD, it must meet the following requirements:

(a) A Plan must assure timely resolution of homeowners' complaints covered under § 203.205. Warranties set forth in a Plan must comply with the Magnuson-Moss Warranty—Federal Trade Commission Improvement Act (15 U.S.C. 2301–2312) along with the requirements and criteria set out in this section.

(b) The entire cost to the homeowner for Plan coverage must be prepaid by the builder and, in the case of optional coverage beyond the coverage required under § 203.205, by either the builder or homeowner.

(c) Unexpired Plan coverage must be automatically transferred, without additional cost, to subsequent homeowners.

(d) Issued Plan coverage must be noncancellable by a Plan or its insurance backer(s).

(e) Exclusions from Plan coverage must not defeat coverage objectives stated in § 203.202 and § 203.205 and must permit normal homeowner use of the covered property, including normal maintenance and emergency property protection measures.

(f) Unless prohibited by applicable law, Plans, must, at a minimum, stipulate that all homeowner complaints, including those regarding construction deficiencies and structural defects claims, will be settled in the amount of their actual cost to correct or for the original sales price of the property, whichever is the lesser, subject to a deductible not to exceed a total of $250 for all claims filed by a homeowner during the first two years of coverage and not to exceed a maximum of $250 per claim during the third through the tenth year of coverage. In the case of claims filed by a condominium association, the deductible may not exceed $2500 per claim during the term of Plan coverage. Recurrent claims for structural defects occasioned by a common cause shall be subject to the payment of no more than one deductible. A homeowner shall be liable for deductible only if a builder defaults on warranty performance and the Plan has to make the covered corrections under the builder's warranty, no deductible that may be included in the Plan is applicable.

(g) In the event of any dispute regarding a homeowner complaint or structural defect claim, Plans must, unless prohibited by applicable law, provide for binding arbitration proceedings arranged through the American Arbitration Association or a similar body. The sharing of arbitration charges shall be as determined by the Plan. A Plan may contain prearbitration conciliation provisions at no cost to the homeowner, or provision for judicial resolution of disputes, but arbitration must be an assured recourse for a dissatisfied homeowner.

(h) Where a State has a home protection act or other statutes or regulations that require its approval of Plans, a Plan issuer must demonstrate such approval to HUD as an additional prerequisite to HUD acceptance.

(i) A Plan issuer must provide homeowners an executed coverage contract clearly describing—

(1) The identity of the property covered;

(2) The time at which coverage begins;

(3) The maximum amount of Plan liability;

(4) Noncancellability of the coverage contract by the Plan or its insurance backers;

(5) No-cost transferability of unexpired coverage to successors in title;

(6) The property coverage provided;

(7) Any exclusions from coverage;

(8) Performance standards for resolving homeowner complaints and claims (if standards for complaint and claim adjustment are promulgated as part of a Plan);

(9) Dispute settlement alternatives and procedures;

(10) The names, addresses, and telephone numbers of the Plan and its insurance backers; and

(11) When, to whom, under what conditions, and to what address

homeowners should submit any construction deficiency complaints or structural defects claims.

(j) Where a Plan issuer or its insurer(s) must demonstrate owned, unencumbered financial resources in some minimum amount, in addition to insurance backing, the Plan or its insurer(s) must certify that those or greater resources will be maintained throughout the period of HUD Plan acceptance.

(k) Plans will not be required to warrant that a covered property complies with:

(1) Original dwelling plans and specifications;

(2) Applicable buiding codes; or

(3) Specific terms of a homeowner's contract to purchase a property.

§ 203.205 Plan coverage.

(a) Plan coverage must take effect upon the initial sale of the property to the homeowner as evidenced by the date of settlement.

(b) During the first year of coverage, a Plan must warrant a covered property against significant defects in workmanship and materials if a builder, for any reason, fails to correct them. The Plan also must warrant the correction of problems with, and the restoration of reliable function of, appliances and equipment damaged during installation or improperly installed by the builder.

(c) During the second year of coverage, a Plan must warrant a covered property against defects in the wiring, piping and ductwork in the electrical plumbing, heating, cooling, ventilating, and mechanical systems.

(d) From the effective date through the end of the second year of coverage, a builder must warrant a covered property against structural defects. From the beginning of the third year through the end of the tenth year of coverage, a Plan must provide this warranty, except that if a builder fails to honor the warranty in the first two years of coverage, the Plan issuer will be responsible for curing any structural defects.

The coverage described in paragraphs (b) thorugh (d) of this section is the minimum level of coverage that HUD will find acceptable in a Plan. A Plan issuer may elect to provide coverage in excess of the minimum required coverage, either in the Plan's basic coverage or by use of a prepaid added-cost endorsement issued at the inception of original property coverage. Nothing in this section precludes private risk-sharing arrangements between a Plan issuer and a builder.

§ 203.206 Housing performance standards or criteria.

A Plan may contain housing performace standards or criteria for resolution of homeowner claims or complaints that are fair, reasonable, and consistent with the intent of the Plan, including Plan coverage under § 203.205. If a Plan contains such criteria or standards, they must be acceptabe to the Secretary.

§ 203.207 Financial strength criteria.

HUD will evaluate Plans for acceptability with respect to their financial strength based on the following criteria:

(a) A Plan offered for acceptance or acceptance renewal directly by an insurance company that is, at the time the Plan is offered, rated A or better by the A.M. Best Company, is presumptively acceptable.

(b) In the following cases, to be acceptable—

(1) A Plan with insurance backing by an insurance company currently rated A or better by the A.M. Best Company must have unencumbered financial resources of at least $250,000 and insurance backing in at least the amount of total potential Plan obligations, as defined in § 203.208 of this chapter.

(2) A Plan offered by a multiple-line insurance company that is currently either unrated, or rated less than A, by the A.M. Best Company, must have reinsurance in at least the amount of total potential Plan obligations, as defined in § 203.208 of this chapter.

(3) A Plan offered by a single-line insurance company that is currently either unrated, or rated less than A, by the A.M. Best Company, or a Plan that is offered by a risk retention group, must have unencumbered financial resources of at least $250,000, and

(i) If the Plan retains no coverage risk, it must have insurance or reinsurance coverage in at least the amount of total potential Plan obligations;

(ii) If the Plan retains a portion of its coverage risk that is calculable in dollars, it must show that the Plan's unencumbered financial resources exceed its retained risk and that the sum of those resources plus the amount of the Plan's reinsurance at least equals total potential Plan obligations; or

(iii) If the Plan retains all of its coverage risk, or a portion of that risk which cannot be reliably expressed in dollars, the Plan issuer must demonstrate that it has either unencumbered financial resources or reinsurance in an amount at least equal to total potential Plan obligations;

(4) A Plan offered by a housing warranty company or builder must have unencumbered financial resources of $250,000 and insurance backing in at least the amount of total potential Plan obligations.

When a Plan is operated by a builder, its operations must be conducted through a corporate legal entity separate from the builder's other business affairs.

(c) Where financial resources must be shown, a Plan issuer must submit a copy of its most current financial statement along with a copy of the certified audit (the audit must be no more than one year old) that was submitted to a State regulatory commission having jurisdiction over this operations. HUD may require clarification from a Plan issuer with respect to its financial statement, if HUD determines that neither the audit nor the financial statement clearly identifies the items that represent unencumbered financial resources.

(d) Surety bonds or letters of credit are not acceptable in lieu of unencumbered financial resources or insurance backing.

§ 203.208 Potential plan obligations.

A Plan issuer must estimate the Plan's potential obligations by using the methodology set forth in this section. The methodology is based upon representative long-term industry claims experience to provide a reasonable forecast of potential future claims.

(a) A Plan's potential obligations for a

policy year (computed for the policy year in which written) will be determined by applying the relevant multiplier (based upon the number of homes covered or to be covered in a policy year as shown in Table I) to that year's contingent liability (*i.e.*, the total sales price of all homes covered during the policy year).

(b) For each full year that has elapsed since a Plan's policy year business was written, the potential Plan obligations for that year must be reduced by ten percent. Computation of potential Plan obligations, adjusted by such reduction, must be made for each policy year. The adjusted amounts represent the estimated remaining potential Plan obligations for each policy year. A Plan may subdivide the policy year into policy months to compute adjustments to partial expiration of policy terms.

(c) For purposes of this section, total potential Plan obligations are the sum of the remaining potential obligations for each policy year for which coverage is still outstanding plus an estimate of the potential plan obligations for the forthcoming policy year. Total potential Plan obligations do not include allowances for day-to-day promotional and operating expenses, or expenses related to travel, claims adjustment, homeowner service, or other expense items. A Plan issuer must, if requested by HUD, provide assurance to the satisfaction of HUD that it has adequate resources to cover these expenses.

TABLE I—MULTIPLIERS TO BE USED FOR COMPUTATION OF POTENTIAL PLAN OBLIGATIONS

Number of homes covered or to be covered during a policy year	Multiplier [1]	Number of homes covered or to be covered during a policy year	Multiplier [1]
1	0.0201	3,500	0.0030
10	.0117	4,000	.0029
20	.0100	4,500	.0028
30	.0091	5,000	.0028
40	.0085	6,000	.0027
50	.0081	7,000	.0026
60	.0077	8,000	.0025
70	.0075	9,000	.0024
80	.0072	10,000	.0024
90	.0070	15,000	.0021
100	.0069	20,000	.0020
150	.0063	25,000	.0019
200	.0059	30,000	.0018
250	0056	35,000	.0018
300	.0053	40,000	.0017
350	.0051	45,000	.0017
400	.0050	50,000	.0016
450	.0048	60,000	.0016
500	.0047	70,000	.0015
600	.0045	80,000	.0015
700	.0044	90,000	.0014
800	.0042	100,000	.0014
900	.0041	150,000	.0013
1,000	.0040	200,000	.0012
1,500	.0037	250,000	.0011
2,000	.0034	300,000	.0011
2,500	.0033	350,000	.0010
3,000	.0031	400,000	.0010

[1] Linear (straight line) interpolation may be used between tabular values.

The fraction of contingent liability that must be used in computing potential Plan obligations for a policy year is shown as a multiplier in the Table. The fraction diminishes as a Plan's business volume increases and provides a large base for risk-averaging. (For illustrative purposes, sample computations of potential Plan obligations are included in Appendix "A" following the Table.)

APPENDIX A—SAMPLE COMPUTATIONS OF POTENTIAL PLAN OBLIGATIONS [1]

Policyyear	No. of homes covered during policy year	Average sales price of homes covered during policy year	Contingent liability (total value of all homes covered during policy year)	Multiplier (from Table 1)	Potential obligation for policy year business when written	Adjusted potential obligation for remaining coverage term
1	2	3	4	5	6	7
1. A Plan began business on September 5, 1985 and does its accounting on a calendar year basis, so that all coverage it writes during 1985 will be reported for its 1985 policy year. The Plan's annual business volumes and sales prices of covered properties are estimated by the Plan as shown in the following Table. Computation made in October 1985.						
1985	600	$87,000	$52,200,000	0.0045	$234,900	$234,900
1986	3,600	90,000	270,000,000	.0031	837,000	837,000
Potential Plan obligations =						$1,071,900

APPENDIX A—SAMPLE COMPUTATIONS OF POTENTIAL PLAN OBLIGATIONS [1]—Continued

Policyyear	No. of homes covered during policy year	Average sales price of homes covered during policy year	Contingent liability (total value of all homes covered during policy year)	Multiplier (from Table 1)	Potential obligation for policy year business when written	Adjusted potential obligation for remaining coverage term
1	2	3	4	5	6	7
2. A Plan began business on March 17, 1980 and its accounting for policy years began each succeeding March 17. Accordingly, its 1980 policy year began on March 17, 1980 and ended on March 16, 1981. For each of its policy years, the Plan's business volume and the average sales price of covered properties are as shown in the following Table. Computation made in April 1985.						
1980	894	$68,700	$61,417,800	0.0041	$251,813	$125,906
1981	2,000	75,000	150,000,000	.0034	510,000	306,000
1982	4,500	79,400	357,300,000	.0028	1,000,440	700,308
1983	6,220	81,300	505,686,000	.0027	1,365,352	1,092,282
1984	8,760	86,200	755,112,000	.0024	$1,812,269	1,631,042
1985 est	10,000	88,000	880,000,000	.0024	2,112,000	2,112,000
Total Potential Plan obligations =						$5,967,538

[1] Notes: Data in columns 1, 2 and 3 or 4 to be supplied by a Plan. Multiplier in column 5 obtained from Table 1, entering Table with data in column 2 and interpolating as necessary.
Figures in column 6 are the product of figures in columns 4 and 5.
Figures in column 7 are those in column 6 reduced by 10 percent for each completed year of coverage for a given policy year's business.

§ 203.209 Insurance backing criteria.

(a) An insurance company backing or operating a Plan must be duly licensed or approved (and with the Plan filed and approved where appropriate) to market such insurance coverage by the proper regulatory agency in each State or Territory in which the Plan will operate. Any company operating under the Product Liability Risk Retention Act of 1981 will be regarded as having met licensing, filing, and approved requirements of all States, but must first demonstrate that it—

(1) Meets licensing, filing and approval requirements in its domiciliary State; and

(2) Meets each of the requirements of paragraphs (A) through (E) of section 4(a) of the Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901(a)(4)(A) through (H)

(b) HUD will consider the insurance backing of a Plan acceptable, if such backing is by:

(1) An insurance company currently rated A or better by the A.M. Best Company;

(2) A multiple-line insurance company currently unrated, or rated less than A, by the A.M. Best Company, with reinsurance in at least the amount of total potential Plan obligations; or

(3) A single-line insurance company currently unrated, or rated less than A, by the A.M. Best Company, and which:

(i) Has reinsurance in at least the amount of total potential Plan obligations; or

(ii) Owns unencumbered financial resources in excess of any retained risk and in at least the amount of the total potential Plan obligations less the demonstrated amount of its reinsurance.

(c) Reinsurance of an insurer's risks under a Plan will be acceptable only if provided by an insurance company currently rated A or better by the A.M. Best Company.

(d) When more than one insurer or reinsurer provides insurance backing of a Plan, the conditions precedent to assumption of liability by each insurer and the amount of each insurer's liability must be shown. There must be complete coverage of total potential Plan obigations.

(e) HUD will consider the following factors when evaluating the acceptability of the coverage provided by reinsurance:

(1) If a percentage of all risk is "laid off", the reinsurance will be evaluated as covering that percentage.

(2) Where the reinsurance provides an annual "low cap", it will be evaluated as covering potential Plan obligations for a policy year only in amount greater than the loss cap. If the loss cap applies to total Plan business rather than to its business by policy year, the Plan must show the actual amount of liability coverage provided by the reinsurance.

(3) Where the reinsurance provides backing of individual home coverage losses greater than some specified amount, the Plan must show the actual amount of liability coverage provided by the reinsurance.

PART 221—LOW COST AND MODERATE INCOME MORTGAGE INSURANCE

8. The authority citation for Part 221 would continue to read as follows:

Authority: Secs. 211, 221, National Housing Act (12 U.S.C. 1715b, 1715l); sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

9. In § 221.20, paragraph (a)(2)(iv) would be revised to read as follows:

§ 221.20 Maximum mortgage amount—loan-to-value limitation.

(a) * * *

(2) * * *

(iv) Is covered by a consumer protection or warranty plan acceptable to the Secretary and satisfies all requirements that would have been applicable if such dwelling had been approved for mortgage insurance before the beginning of construction. After [insert date six months following effective date], any consumer protection or warranty plan must meet the requirements of §§ 203.200–203.209 of this chapter.

* * * * *

PART 222—SERVICEMEN'S MORTGAGE INSURANCE

10. The authority citation for Part 222 would continue to read as follows:

Authority: Secs. 211, 222, National Housing Act (12 U.S.C. 1715b, 1715m); sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

11. In § 222.4, paragraph (a)(4) would be revised to read as follows:

§ 222.4 Maximum mortgage amount; loan-to-value limitation.

(a) * * *

(4) Is covered by a consumer protection or warranty plan acceptable to the Secretary and satisfies all requirements that would have been applicable if such dwelling had been approved for mortgage insurance before the beginning of construction. After [insert date six months following effective date], any consumer protection or warranty plan must meet the requirements of §§ 203.200–203.209 of this chapter.

* * * * *

PART 226—ARMED SERVICES HOUSING—CIVILIAN EMPLOYEES [SECTION 809]

12. The authority citation for Part 226 would continue to read as follows:

Authority: Secs. 807, 809, National Housing Act (12 U.S.C. 1748f, 1748h–1); sec. 7(d); Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

13. In § 226.5, paragraph (a)(1)(iii) would be revised to read as follows:

§ 226.5 Maximum mortgage amount; loan-to-value limitation.

(a) * * *

(1) * * *

(iii) Is covered by a consumer protection or warranty plan acceptable to the Secretary and satisfies all requirements that would have been applicable if such dwelling had been approved for mortgage insurance before the beginning of construction. After [insert date six months following effective date], any consumer protection or warranty plan must meet the requirements of §§ 203.200–203.209 of this chapter.

* * * * *

PART 234—CONDOMINIUM OWNERSHIP MORTGAGE INSURANCE

14. The authority citation for Part 234 would continue to read as follows:

Authority: Secs. 211, 234, National Housing Act (12 U.S.C. 1715b, 1715y); sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

15. In § 234.27, paragraph (a)(2)(iii) would be revised to read as follows:

§ 234.27 Maximum mortgage amounts.

(a) * * *

(2) * * *

(iii) Is covered by a consumer protection or warranty plan acceptable to the Secretary and satisfies all requirements that would have been applicable if such dwelling had been approved for mortgage insurance before the beginning of construction. After [insert date six months following effective date], any consumer protection or warranty plan must meet the requirements of §§ 203.200–203.209 of this chapter.

* * * * *

PART 235—MORTGAGE INSURANCE AND ASSISTANCE PAYMENTS FOR HOME OWNERSHIP AND PROJECT REHABILITATION

16. The authority citation for Part 235 would continue to read as follows:

Authority: Secs. 211, 235, National Housing Act (12 U.S.C. 1715b, 1715z); sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

17. In § 235.15, paragraph (a)(2) would be revised to read as follows:

§ 235.15 Eligible types of dwellings.

(a) * * *

(2) A single family dwelling which has never been previously occupied and is covered by a consumer protection or warranty plan acceptable to the Secretary and satisfies all requirements that would have been applicable if such dwelling had been approved for mortgage insurance before the beginning of construction. After [insert date six months following effective date], any consumer protection or warranty plan must meet the requirements of §§ 203.200–203.209 of this chapter.

* * * * *

Dated: May 6, 1987.

Thomas T. Demery,

Assistant Secretary for Housing-Federal Housing Commissioner.

[FR Doc. 87–12966 Filed 6–9–87; 8:45 am]

BILLING CODE 4210–27–M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[FRL–3215–7]

Approval and Promulgation of Implementation Plans, North Carolina; Extension of Public Comment Period

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of extension of public comment period.

SUMMARY: On April 29, 1987, (52 FR 15514), EPA granted a 30-day extension to May 27, 1987 for the comment period for the proposed disapproval of the North Carolina implementation plan's revised limits for particulate emissions from electric utility boilers. On May 15, 1987, Carolina Power and Light Company (CP&L) requested an additional 30 days to June 26, 1987. Today, we are granting that request and this will be the last extension for the comment period.

DATES: Comments are now due on or before June 26, 1987.

FOR FURTHER INFORMATION CONTACT: Roger O. Pfaff, Environmental Protection Agency, 345 Courtland Street, NE., Atlanta, Georgia 30365, telephone (404) 347-2864 or FTS 257-2864.

Dated: June 2, 1987.

Patrick M. Tobin

Acting Regional Administrator.

[FR Doc. 87–13202 Filed 6–9–87; 8:45 am]

BILLING CODE 6560–50–M

40 CFR Part 180

[PP 6E3411/P421; FRL–3215–3]

Pesticide Tolerance for 2-[1-(Ethoxyimino)Butyl]-5-[2-(Ethylthio)-Propyl]-3-Hydroxy-2-Cyclohexen-1-One

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: This document proposes that tolerances be established for the combined residues of the herbicide 2-[1-(ethoxyimino)-butyl]-5-[2-(ethylthio)propyl]-3-hydroxy-2-cyclohexen-1-one and its metabolites in or on the raw agricultural commodities flaxseed and flax straw. The proposed regulation to establish maximum permissible levels for residues of the herbicide in or on the commodities was requested in a petition submitted by the Interregional Research Project No. 4 (IR–4).

DATES: Comments, identified by the document control number [PP 6E3411/P421], should be received on or before June 25, 1987.

ADDRESS:

By mail, submit written comments to: Information Services Section, Program Management and Support Division (TS–757C), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460

In person, bring comments to: Rm. 236, CM #2, 1921 Jefferson Davis Highway, Arlington, VA 22202.

Information submitted as a comment concerning this notice may be claimed confidential by marking any part or all

of that information as "Confidential Business Information" (CBI). Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR Part 2. A copy of the comment that does not contain CBI must be submitted for inclusion in the public record. Information not marked confidential may be disclosed publicly by EPA without prior notice. All written comments will be available for public inspection in Rm. 236 at the address given above, from 8 a.m. to 4 p.m., Monday through Friday, excluding holidays.

FOR FURTHER INFORMATION CONTACT:

By mail: Donald R. Stubbs, Emergency Response and Minor Use Section (TS-767C), Registration Division, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460

Office location and telephone number: Rm. 716B, CM #2, 1921 Jefferson Davis Highway, Arlington, VA 22202, (703-557-1806).

SUPPLEMENTARY INFORMATION: The Interregional Research Project No. 4 (IR-4), New Jersey Agricultural Experiment Station, P.O. Box 231, Rutgers University, New Brunswick, NJ 08903, submitted pesticide petition 6E3411 to EPA on behalf of Dr. Robert H. Kupelian, National Director, IR-4 Project and the Agricultural Experiment Station of North Dakota.

This petition requested that the Administrator, pursuant to section 408(e) of the Federal Food, Drug, and Cosmetic Act, propose the establishment of tolerances for the combined residues of the herbicide 2-[1-(ethoxyimino)butyl]-5-[2-(ethylthio)propyl]-3-hydroxy-2-cyclohexen-1-one and its metabolites containing the 2-cyclohexen-1-one moiety (calculated as the herbicide) in or on the raw agricultural commodities flaxseed at 5.0 parts per million (ppm) and flax straw at 2.0 ppm. In addition, IR-4 has submitted a related food additive petition 7H5528 proposing a regulation to permit residues of the herbicide on flaxseed meal at 7 ppm, resulting from application to the growing crop.

The data submitted in the petition and other relevant material have been evaluated. The pesticide is considered useful for the purpose for which the tolerances are sought. The toxicological data considered in support of the proposed tolerances include:

1. A 6-month dog feeding study with a no-observed-effect (NOEL) level of 2 milligrams (mg)/kilogram (kg)/day.

2. A 2-year chronic feeding/oncogenicity study in rats with a NOEL greater than 360 ppm (equivalent to 18 mg/kg/day, highest dose tested) and no oncogenic effects observed under the conditions of the study at all dose levels tested (40, 120, and 360 ppm).

3. A 2-year chronic feeding/oncogenicity study in mice with a NOEL of 120 ppm (18 mg/kg/day) and no oncogenic effects observed under the conditions of the study at all dose levels tested (0, 40, 120, 360, and 1,080 ppm).

4. A 2-generation reproduction study in rats with a NOEL of 360 ppm (18 mg/kg/day).

5. A teratology study in rats with no observed teratogenic effects at 250 mg/kg/day (highest dose tested) and a NOEL of 40 mg/kg/day for maternal toxicity.

6. A teratology study in rabbits with a NOEL for teratogenic effects and maternal toxicity at 160 mg/kg/day.

7. Mutagenicity studies including recombinant assays and forward mutations in *B subtilis, E. coli,* and *S. typhimurium* (negative at concentrations of chemical to 100 percent), and a host-mediated assay (mouse) with *S. typhimurium* (negative at 2.5 grams (gms)/kg/day of chemical).

8. A metabolism study in rats which showed negligible accumulation and extremely rapid excretion of the chemical.

The acceptable daily intake (ADI), based on the 6-month dog feeding study NOEL of 2 mg/kg/day (equivalent to 60 ppm) and using a 100-fold safety factor, is calculated to be 0.02 mg/kg of body weight/day. The maximum permitted intake (MPI) for a 60-kg human is calculated to be 1.2 mg/day. Pending and published tolerances utilize 69.75 percent of the ADI, the current action will utilize an additional 0.2 percent.

The nature of the residues is adequately understood and an adequate analytical method, gas-liquid chromatography using a flame photometric detector, is available for enforcement purposes. Analytical enforcement methods are currently available in the Pesticide Analytical Manual (PAM), Volume II. There are currently no actions pending against the continued registration of this chemical.

Tolerances established for residues in meat, milk, poultry, and eggs are adequate to cover secondary residues resulting from the feeding of flax feed products. The grazing or feeding of treated flax forage will be prohibited. Based on the information and data considered, the Agency concludes that the tolerances will protect the public health. Therefore, it is proposed that the tolerances be established as set forth below.

Any person who has registered or submitted an application for registration of a pesticide, under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) as amended, which contains any of the ingredients listed herein, may request within 15 days after publication of this notice in the **Federal Register** that this rulemaking proposal be referred to an Advisory Committee in accordance with section 408(e) of the Federal Food, Drug, and Cosmetic Act. As provided for in the Administrative Procedure Act (5 U.S.C. 553(d)(3)), the comment period time is shortened to fewer than 30 days because of the necessity to expeditiously provide a means for control of grasses in flax.

Interested persons are invited to submit written comments on the proposed regulation. Comments must bear a notation indicating the document control number, [PP 6E3411/P421]. All written comments filed in response to this petition will be available in the Information Services Section, at the address given above from 8 a.m. to 4 p.m., Monday through Friday, except legal holidays.

The Office of Management and Budget has exempted this rule from the requirements of section 3 of Executive Order 12291.

Pursuant to the requirements of the Regulatory Flexibility Act (Pub. L. 96-354, 94 Stat. 1164, 5 U.S.C. 601-612), the Administrator has determined that regulations establishing new tolerances or raising tolerance levels or establishing exemptions from tolerance requirements do not have a significant economic impact on a substantial number of small entities. A certification statement to this effect was published in the **Federal Register** of May 4, 1981 (46 FR 24950).

List of Subjects in 40 CFR Part 180

Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Recording and recordkeeping requirements.

Dated: May 26, 1987.

Edwin F. Tinsworth,

Director, Registration Division, Office of Pesticide Programs.

PART 180—[AMENDED]

Therefore, it is proposed that 40 CFR Part 180 be amended as follows:

1. The authority citation for Part 180 continues to read as follows:

Authority: 21 U.S.C. 346a.

2. Section 180.412 is amended by adding and alphabetically inserting the

raw agricultural commodities to read as follows:

§ 180.412 2-[1-(Ethoxyimino)butyl]-5-[2-(ethylthio)propyl]-3-hydroxy-2-cyclohexen-1-one; tolerances for residues.

* * * * *

Commodities	Parts per million
* * * * *	
Flaxseed	5.0
Flax straw	2.0
* * * * *	

[FR Doc. 87-12964 Filed 6-9-87; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 87-169, RM-5489 and RM-5591]

Radio Broadcasting Services; Punta Gorda, FL

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This document requests comments on two petitions for rule making. The first, filed by Ogden Broadcasting of Florida, Inc., licensee of Station WQLM(FM), Punta Gorda, Florida, seeks to substitute Channel 225C2 for Channel 224A, and to modify its Class A license to specify the Class C2 channel. The second, filed by Sea Breeze Broadcasting Company proposes to allot Channel 222A to Punta Rassa, Florida, as a first FM channel. These proposals are mutually exclusive as they do not meet the required mileage separation for third adjacent A to C2 channels (55 kilometers).

DATES: Comments must be filed on or before July 27, 1987, and reply comments on or before August 12, 1987.

ADDRESS: Federal Communications Commission, Washington, DC 20554. In addition to filing comments with the FCC, interested parties should serve the petitioner, or its counsel or consultant, as follows: B. Jay Baraff, Esq., 2023 M Street, NW., Suite 203, Washington, DC 20036 (Attorney for Ogden Broadcasting Co.) (2) Lyle R. Evans, 1145 Pine Street, Green Bay, Wisconsin 54301 (Consultant for Sea Breeze Broadcasting Company).

FOR FURTHER INFORMATION CONTACT: Montrose H. Tyree, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Notice of Proposed Rule Making, MM Docket No. 87-169, adopted May 5, 1987, and released June 4, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW, Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1231 for rules governing permissible *ex parte* contact.

For information regarding proper filing procedures for comments, See 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Federal Communications Commission.

Mark N. Lipp,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 87-13236 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 25

Revision of the General Provisions for Fees and Charges to Include Criteria for Establishing and Collecting Entrance Fees on National Wildlife Refuges; Reopening of Comment Period

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule; reopening of comment period.

SUMMARY: This action reopens the comment period for the proposed rule stated above which was published in the **Federal Register** on May 11, 1987 (52 FR 17613). This action also provides additional information by clarifying the use of revenues generated and identifying specific refuges being considered for initiation of fee collection.

In order to clarify the statement in the proposed rule that revenues generated will be used for the conservation of wetland resources and for the operation and maintenance of refuges, the following is taken from the Emergency Wetlands Resources Act of 1986: Thirty percent of the revenues collected shall be used, first, to defray the cost of collection; second, for the operation and maintenance of the collecting unit; and third, for operation and maintenance of all units within the National Wildlife Refuge System, except those in Alaska. Seventy percent of the revenues collected shall be deposited into the Migratory Bird Conservation Fund which provides for the acquisition of wetland habitat. These percentages apply only to the revenue generated from the single visit permits and Golden Eagle Passports sold at the collecting refuges. No fees are charged for Golden Age or Access Passports. Further, as required by the Migratory Bird Hunting and Conservation Stamp Act of 1934, All revenue generated from the purchase of the Federal Migratory Bird Hunting and Conservation (Duck) Stamp shall be deposited in the Migratory Bird Conservation Fund.

National wildlife refuges being considered as candidate sites for the collection of entrance fees are: Aransas (TX), Bosque Del Apache (NM), Chincoteague (VA), DeSoto (IA), Ding Darling (FL), Dungeness (WA), Edwin B. Forsythe (Brigantine Division) (NJ), Hobe Sound (FL), Kilauea Point (HI), Loxahatchee (FL), McKay Creek (OR), Montezuma (NY), Muscatatuck (IN), Ottawa (OH), Parker River (MA), National Bison Range (MT), Seney (MI), Sequoyah (OK), Sherburne (MN) and St. Marks (FL).

DATE: Comments must be submitted on or before June 25, 1987.

ADDRESS: Assistant Director, Refuges and Wildlife, Fish and Wildlife Service, Room 3248, 18th and C Streets, NW., Washington, DC 20240.

FOR FURTHER INFORMATION CONTACT: Jim Gillett, Division of Refuges, at (202) 343-4311.

Dated: June 5, 1987.

Steve Robinson,

Deputy Director.

[FR Doc. 87-13178 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-55-G

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 642

[Docket No. 70605-7105]

Coastal Migratory Pelagic Resources of the Gulf of Mexico and the South Atlantic

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Notice of preliminary change in total allowable catch and bag limits for king and Spanish mackerel.

SUMMARY: The Secretary of Commerce issues a notice of preliminary change in the total allowable catch (TAC) for the Gulf migratory group of king mackerel and the Atlantic and Gulf migratory groups of Spanish mackerel and bag limits for Spanish mackerel in accordance with the framework procedure of the Fishery Management Plan for the Coastal Migratory Pelagic Resources of the Gulf of Mexico and the South Atlantic (FMP). This notice proposes (1) reductions in TAC and allocations for the Gulf migratory group of king mackerel and the Atlantic and Gulf migratory groups of Spanish mackerel; and (2) bag limits for Spanish mackerel from both migratory groups. The intended effects are to protect the mackerels and still allow a catch by the important recreational and commercial fisheries that are dependent on these species.

DATES: Written comments must be received on or before June 24, 1987.

ADDRESSES: Comments should be sent to William N. Lindall, Southeast Region, National Marine Fisheries Service, 9450 Koger Boulevard, St. Petersburg, FL 33702.

FOR FURTHER INFORMATION CONTACT: Willian N. Lindall, 813-893-3721.

SUPPEMENTARY INFORMATION: The mackerel fisheries are regulated under the FMP, which was prepared jointly by the Gulf of Mexico and South Atlantic Fishery Management Councils (Councils), and its implementing regulations at 50 CFR Part 642. Amendment 1 to the FMP was implemented Septebmer 22, 1985 (50 FR 3843), August 28, 1985). A proposed rule to implement Amendment 2 was published April 29, 1987 (52 FR 15519). This notice proposes specific bag limits for Spanish mackerel that were reserved in the proposed rule and proposes changes to the TACs and allocations for Spanish mackerel in that proposed rule. The final rule to implement Amendment 2 is expected to be effective at about the same time as the final action on this notice.

In accordance with § 642.27, the Councils appointed an assessment group (Group) to assess on an annual basis the condition of each stock of king and Spanish mackerel in the management unit, to report its findings, and to make recommendations to the Councils. Based on the report and recommendations of the Group, advice from the Mackerel Advisory Panel and the Scientific and Statistical Committee, and public input, the Councils recommended to the Regional Director, Southeast Region, NMFS (MD), changes to TACs, allocations, quotas, and bag limits.

Specifically, the Councils recommended that, effective with the fishing year beginning July 1, 1987, annual TACs be set at 2.2 million pounds (m. lbs) for Gulf migratory group king mackerel and 2.5 m. lbs. for Gulf migratory group Spanish mackerel. The Councils further recommended that effective for the fishing year which began April 1, 1987, annual TACs remain at 9.68 m. lbs. for Atantic migratory group king mackerel and be set at 3.1 m. lbs. for Atlantic migratory group Spanish mackerel. All TACs are within the range of acceptable biological catch provided by the Group.

In accordance with the provisions of the FMP, the recreational fishery and the commercial fishery are each allocated a fixed percentage of each TAC and the Gulf king mackerel commercial allocation is subdivided into quotas for eastern and western zones. Under the fixed percentages and the proposed TACs, allocations and quotas would be as follows:

	(pounds)
Gulf King Mackerel-TAC	2.2 m.
Recreational allocation (68%)	−1.5 m.
Commercial allocation (32%)	−0.7 m.
Eastern zone (69%)	−0.5 m.
Western zone (31%)	−0.2 m.
Gulf Spanish Mackerel-TAC	2.5 m.
Recreational allocation (43%)	−1.08 m.
Commercial allocation (57%)	−1.42 m.
Atlantic King Mackerel-TAC:	9.68 m.
Recreational allocation (62.9%)	−6.09 m.
Commercial allocation (37.1%)	−3.59 m.
Atlantic Spanish Mackerel-TAC	3.10 m.
Recreational allocation (24%)	−0.74 m.
Commercial allocation (76%)	−2.36 m.

In amendment 2 to the FMP, the Councils proposed a ban on the use of purse seines in the exclusive economic zone (EEZ) to harvest any of the commercial allocations. The Regional Director's decision to approve the prohibition, except with regard to the Atlantic migratory group of king mackerel, is reflected in the final rule implementing Amendment 2.

The recreational fishery is regulated by both allocations and bag limits. The Council recommended no changes in the bag limits applicable to king mackerel. For Spanish mackerel, the Councils recommended for the Gulf migratory group three fish per person per trip and for the Atlantic migratory group four fish per person per trip off Florida (southern area) and ten fish per person per trip off North Carolina, South Carolina, and Georgia (northern area).

The 10-fish bag limit would provide those persons fishing in the northern area an opportunity to catch Spanish mackerel from offshore areas where there are thinly distributed, seasonal fisheries. The estimated percentage of reduction of catch in both areas is the same, 25 percent.

The Regional Director concurs that the Councils' recommendations are necessary to protect the stocks and prevent overfishing and that they are consistent with goals and objectives of the FMP, the national standards, and other applicable law. Accordingly, the Council's recommended changes are published.

Classification

This action is authorized by 50 CFR 642.27, and complies with E.O. 12291.

The Councils prepared a supplemental regulatory flexibility analysis for the rule which authorizes this action and a supplemental regulatory impact review for this action. You may obtain copies from the address below.

List of Subjects in 50 CFR Part 642

Fisheries, Fishing, Reporting and recordkeeping requirements.

Dated: June 4, 1987.

James E. Douglas, Jr.,

Deputy Assistant Administrator For Fisheries, National Marine Fisheries Service.

PART 642—COASTAL MIGRATORY PELAGIC RESOURCES OF THE GULF OF MEXICO AND THE SOUTH ATLANTIC

For reasons set forth in the preamble, 50 CFR Part 642 is proposed to be amended as follows:

1. The authority citation for Part 642 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

2. In § 642.21, paragraphs (a)(1), (b)(1), (c), and (d) are revised, paragraph (e) is removed, and paragraph (f) is redesignated as (e) to read as follows:

§ 642.21 Quotas and allocations.

(a) * * *

(1) The commercial allocation for the Gulf migratory group of king mackerel is 0.7 million pounds per fishing year. This allocation is divided into quotas as follows:

(i) 0.5 million pounds for the eastern allocation zone; and

(ii) 0.2 million pounds for the western allocation zone.

* * * * *

(b) * * *

(1) The recreational allocation for the Gulf migratory group of king mackerel is 1.5 million pounds per fishing year.

* * * * *

(c) *Commercial allocations for Spanish mackerel.* (1) The commercial allocation for the Gulf migratory group of Spanish mackerel is 1.42 million pounds per fishing year.

(2) The commercial allocation for the Atlantic migratory group of Spanish mackerel is 2.36 million pounds per fishing year.

(d) *Recreational allocations for Spanish mackerel.* (1) The recreational allocation for the Gulf migratory group of Spanish mackerel is 1.08 million pounds per fishing year.

(2) The recreational allocation for the Atlantic migratory group of Spanish mackerel is 0.74 million pounds per fishing year.

* * * * *

3. In § 642.28, paragraph (a), introductory text, paragraph (a)(1) heading, and paragraph (a)(2) are revised and paragraphs (a)(3) and (a)(4) are added to read as follows:

§ 642.28 Bag and possession limits.

(a) *Bag limits.* A person who fishes for king or Spanish mackerel from the Gulf or Atlantic migratory group (see Figure 2) in the EEZ, except a person fishing under a permit specified in § 642.4 and an allocation specified in § 642.21(a) or (c), or possessing the purse seine catch allowance specified in § 642.24(b), is limited to the following:

(1) *King mackerel Gulf migratory group.* * * *

(2) *King mackerel Atlantic migratory group.* Possessing three king mackerel per person per trip.

(3) *Spanish mackerel Gulf migratory group.* Possessing three Spanish mackerel per person per trip.

(4) *Spanish mackerel Atlantic migratory group.* (i) Possessing four Spanish mackerel per person per trip from the southern area.

(ii) Possessing ten Spanish mackerel per person per trip from the northern area.

(iii) For purposes of this paragraph (a)(4) of this section, the boundary between the northern and southern areas is 30°42'45.6" N. latitude.

* * * * *

[FR Doc. 87-13161 Filed 6-9-87; 8:45 am]
BILLING CODE 3510-22-M

Notices

Federal Register
Vol. 52, No. 111
Wednesday, June 10, 1987

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Forms Under Review by Office of Management and Budget

June 5, 1987.

The Department of Agriculture has submitted to OMB for review the following proposals for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35) since the last list was published. This list is grouped into new proposals, revisions, extensions, or reinstatements. Each entry contains the following information:

(1) Agency proposing the information collection; (2) Title of the information collection; (3) Form number(s), if applicable; (4) How often the information is requested; (5) Who will be required or asked to report; (6) An estimate of the number of responses; (7) An estimate of the total number of hours needed to provide the information; (8) An indication of whether section 3504(h) of Pub. L. 96-511 applies; (9) Name and telephone number of the agency contact person.

Questions about the items in the listing should be directed to the agency person named at the end of each entry. Copies of the proposed forms and supporting documents may be obtained from: Department Clearance Officer, USDA, OIRM, Room 404-W Admin. Bldg, Washington, DC 20250, (202) 447-2118.

Comments on any of the items listed should be submitted directly to: Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503, Attn: Desk Officer for USDA.

If you anticipate commenting on a submission but find that preparation time will prevent you from doing so promptly, you should advise the OMB Desk Officer of your intent as early as possible.

Extension

- Agricultural Stabilization and Conservation Service Certificaitons for Eligibility to Receive Price Support on Flue-cured Tobacco
  MO-32
  Annually
  Individuals or households; Farms; 110,000 responses; 5,500 hours; not applicable under 3504(h)
  Sarah J. Matthews (202) 475-5012

Reinstatement

- Agricultural Stabilization and Conservation Service Agreements Relative to Receiving Price Support on Tobacco
  MO-38
  Annually
  Individuals or households; Farms; 290,500 responses; 14,525 hours; not applicable under 3504(h)
  Donald M. Blythe (202) 382-0200
- Agricultural Stabilization and Conservation Service Warehouseman's Report of Space Availability
  KC-140
  Semi-monthly
  Businesses or other for-profit; Federal agencies or employees; Small businesses or organizations; 900 responses; 225 hours; not applicable under 3504(h)
  Donnie L. McClure (816) 926-6024
- Food and Nutrition Service
  7 CFR Part 251—Temporary Emergency Food Assistance Program
  SF-269, SF-270
  On occasion; Monthly; Quarterly; Annually
  Individuals or households; State or local governments; 17,015 responses; 704,300 hours; not applicable under 3504(h)
  Barbara Batts (703) 756-3660

Larry K. Roberson,

Acting Departmental Clearance Officer.

[FR Doc. 87-13245 Filed 6-9-87; 8:45 am]

BILLING CODE 3410-10-M

Forest Service

Valle Vidal Area Amendment to the Carson National Forest Land Management Plan, Carson National Forest, Taos & Colfax Counties, NM; Intent To Prepare an Environmental Impact Statement

Purpose and Need: The Department of Agriculture, Forest Service, will prepare an environmental impact statement for the management of the Valle Vidal Management Area on the Carson National Forest. This environmental analysis will establish the integrated management prescriptions for the area. It will be developed under regulations pursuant to the National Environmental Policy Act (NEPA) (40 CFR Parts 1500-1508) and the National Forest Management Act (NFMA) (36 CFR Part 219).

In early 1982, the Pennzoil Company of Houston, Texas, donated 101,794 acres of its 492,560-acre Vermejo Ranch in northeastern New Mexico to the people of the United States through the Forest Service, U.S. Department of Agriculture. It is now a part of the Carson National Forest.

The area is known as the Valle Vidal Area (formerly called the Vermejo Unit) and is administered for its resource values consisting of minerals, timber, grazing, fisheries, and wildlife, etc. Outstanding scenic and recreation values have been available for public enjoyment. Outdoor recreation opportunities include camping, hiking, fishing, hunting, cross-country skiing, and birdwatching.

The Multiple Use Area Gude was approved April 7, 1983, and provides interim management direction for the area. The Decision Notice directs that the management of the area be "multiple use management of the land for its unique combination of wildland resources, primarily public outdoor recreation, continued timber production, forage for livestock and wildlife, unique wildlife habitat and watershed."

Interim implementation plans are in effect for managing resources such as: forage allocation, recreation management, access, etc. in accord with the coordinating requirements in the multiple use area guide.

Forest Plan: The Carson Forest Plan was implemented in December 1986. The Record of Decision for the Forest Plan EIS (October 31, 1986) deferred the allocation decision on the Valle Vidal to this environmental analysis.

The purpose of this analysis is to define the issues relevant to integrated resource allocations for the Valle Vidal Area, Management Area 21, evaluate alternative management strategies for addressing the identified issues, and recommend the management strategy which will provide the greatest net public benefits from this management area. The results will be compatible with, and become part of the Carson Forest Plan as the Valle Vidal Management Area (page 230 in Forest Plan).

Issues, Concerns & Opportunities: A number of issues and/or concerns have been raised by the public, New Mexico Department of Game and Fish, and Forest Service personnel. Many issues relevant to management of the area were identified during the Forest planning process and during preparation of the various documents guiding present management of this area. A number of public involvement activities have been conducted to identify issues relevant to management of the area.

A number of potential issues have been identified. Many of these are not relevant to the purpose of determining the best integrated resource allocations for this management area. Others are more appropriate for analysis of site specific projects and others are indicators of an underlying allocation issue. Potential issues have been screened and selected as the major issues to be analyzed, i.e., riparian/watershed condition, wildlife, fish, etc.

Public Comments: The Carson National Forest has initiated the scoping process. Individuals, groups and agencies are encouraged to participate or keep themselves informed. Contact: Land Management Planning, Carson National Forest, P.O. Box 558, Taos, New Mexico 87571—(505) 758–6200. A draft of the EIS is presently scheduled to be published in April, 1988, with the EIS being published in October, 1988.

Decision Maker: The Regional Forester is the responsible official who will decide on the management strategy to be implemented on the Valle Vidal Area, Management Area 21.

Dated: May 27, 1987.

Sotero Muniz,

Regional Forester.

[FR Doc. 87–13194 Filed 6–9–87; 8:45 am]

BILLING CODE 3410–11–M

Intent To Prepare an Environmental Impact Statement; Gallatin Marina Reconstruction and Expansion; Lassen National Forest, Lassen County, CA

The Department of Agriculture, Forest Service, is preparing an enviromental impact statement for a long-term facility at Gallatin Marina at Eagle Lake in Lassen County, California. The present facilities are at the end of their 20-year use permit, and some reconstruction or relocation is necessary. The area involved is about 70 acres in section 7, T. 31 N., R. 11 E., MDM.

The environmental impact statement will consider a range of alternatives, ranging from limited reconstruction of the existing facilities, to a major increase in the marina capacity. The environmental consequences for each alternative will be described.

Public involvement activities to date have identified concerns about impacts of marina construction and operation on the following: water quality; fish and other aquatic life; wildlife including osprey; plant populations; recreation opportunities including visual, sound, and air quality impacts; archaeological resources; as well as growth-inducing impacts on private land. The environmental impact statement will address these impacts.

The draft environmental impact statement should be available for public review in July, 1987. After a 45-day public comment period, a final impact statement is scheduled for completion after September, 1987.

Richard A. Henry, Forest Supervisor, Lassen National Forest, is the responsible official for this project. For further information, or to submit additional issues, comments, or questions, contact Steve Young, Resource Officer, Eagle Lake Ranger District, 55 South Sacramento Street, Susanville, CA 96130 (916 257–2151).

Dated: May 28, 1987.

Richard A. Henry,

Forest Supervisor.

[Filed Doc. 87–13184 6–9–8:45 a.m.]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Soil Conservation Service

Brooks Slough Critical Area Treatment RC&D Measure, Washington; Finding of No Significant Impact

AGENCY: Soil Conservation Service.

ACTION: Notice of a Finding of No Significant Impact.

SUMMARY: Pursuant to Section 102(2)(C) of the National Environmental Policy Act of 1969; the Council on Environmental Quality Guidelines, (40 CFR Part 1500); and the Soil Conservation Service Guidelines (7 CFR Part 650); the Soil Conservation Service, U. S. Department of Agriculture, gives notice that an environmental impact statement is not being prepared for the Brooks Slough Critical Area Treatment RC&D Measure, Wahkiakum County, Washington.

FOR FURTHER INFORMATION CONTACT: Mr. Lynn A. Brown, State Conservationist, Soil Conservation Service, West 920 Riverside, Room 360, Spokane, Washington 99201–1080; telephone 509-456-3711.

SUPPLEMENTARY INFORMATION: The environmental assessment of this federally assisted action indicates that the project will not cause significant local, regional, or national impacts on the environment. As a result of these findings, Lynn A. Brown, State Conservationist, has determined that the preparation and review of an environmental impact statement are not needed for this project.

This project concerns a plan to minimize the potential dangers and damages of flooding by improving stability of a severely eroded area approximately one mile southeast of the community of Skamokawa, Wahkiakum County, Washington. Brooks Slough is the outlet from Alger Creek into the Columbia River. The area protected by the proposed project is approximately 160 acres in size, and has within the project boundaries, three land owners, a residence and several farm outbuildings. Land use is pasture and hayland.

The planned works of improvement include the installation of 4,700 feet of fencing and 4,100 feet of rock fill needed to reduce erosion of a dike on the north side of Brooks Slough. The rock fill area will be planted with adapted grasses in any area where the present vegetation is disturbed. Work will be performed in a manner to limit the amount of vegetation disturbed to minimum levels.

This objective agrees with the USDA National Program for Soil and Water Conservation, Soil and Water Resource Conservation Act of 1977 (RCA) and the Columbia-Pacific Resource Conservation and Development Area Plan.

The Notice of a Finding of No Significant Impact (FONSI) has been forwarded to the Environmental Protection Agency and to various

Federal, State, and local agencies and interested parties. A limited number of copies of the FONSI are available to fill single copy requests at the above address. Basic data developed during the environmental assessment are on file and may be reviewed by contacting Lynn A. Brown.

No administrative action on implementation of the proposal will be taken until 30 days after the date of this publication in the **Federal Register.**

(This activity is listed in the Catalog of Federal Domestic Assistance under No. 10.901—Resource, Conservation and Development—and is subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials.)

Dated: June 1, 1987.

Lynn A. Brown,

State Conservationist.

[FR Doc. 87-13151 Filed 6-9-87; 8:45 am]

BILLING CODE 3410-16-M

Halliday RC&D Measure, North Dakota

AGENCY: Soil Conservation Service, USDA.

ACTION: Notice of a Finding of No Significant Impact.

SUMMARY: Pursuant to section 102(2)(c) of the National Environmental Policy Act of 1969; the Council on Environmental Quality Guidelines (40 CFR Part 1500); and the Soil Conservation Service Guidelines (7 CFR Part 650); the Soil Conservation Service, U.S. Department of Agriculture, gives notice that an environmental impact statement is not being prepared for the Halliday Flood Prevention RC&D Measure, Dunn County, North Dakota.

FOR FURTHER INFORMATION CONTACT: Mr. August J. Dornbusch, Jr., State Conservationist, Soil Conservation Service, P.O. Box 1458, Bismarck, North Dakota 58502, telephone (701) 255-4011, extentions 421.

SUPPLEMENTARY INFORMATION: The environmental assessment of this federally assisted action indicates that the project will not cause significant local, regional or national impacts on the environment. As a result of these findings, Mr. August J. Dornbusch, Jr., State Conservationist, has determined that the preparation and review of an environmental impact statement are not needed for this project.

The measure concerns a plan for the installation of a dike, a floodwater diversion, a grade stabilization structure, and a combination bridge grade stabilization structure to reduce flooding to homes and businesses.

The Notice of a Finding of No Significant Impact (FONSI) has been forwarded to the Environmental Protection Agency and to various Federal, State, and local agencies and itnerested parties. A limited number of copies of the FONSI are available to fill single copy requests at the above address. Basic data developed during the environmental assessment are on file and may be reviewed by contacting Mr. August J. Dornbusch, Jr.

No administrative action on implementation of the proposal will be taken until 30 days after the date of this publication in the **Federal Register.**

"(This activity is listed in the Catalog of Federal Domestic Assistance under No. 10.901—Resource Conservation and Development—and is subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials)"

Dated: June 2, 1987.

August J. Dornbusch, Jr.,

State Conservationist.

[FR Doc. 87-13152 Filed 6-9-87; 8:45 am]

BILLING CODE 3410-16-M

DEPARTMENT OF COMMERCE

National Bureau of Standards

National Conference on Weights and Measures; Meeting

AGENCY: National Bureau of Standards, Commerce.

ACTION: Notice of meeting.

SUMMARY: Notice is hereby given that the Annual Meeting of the National Conference on Weights and Measures will be held July 19 through July 24, 1987, at the Excelsior Hotel, Little Rock, Arkansas. The meeting is open to the public.

The National Conference on Weights and Measures is an organization of weights and measures enforcement officials of the States, counties, and cities of the United States, and private sector representatives. The interim meeting of the Conference held in January 1987 at the National Bureau of Standards, as well as the annual meeting to be held in July, brings together enforcement officials, other government officials, and representatives of business, industry, trade associations, and consumer organizations to discuss subjects that relate to the field of weights and measures technology and administration.

Pursuant to section 2(5) of its Organic Act (15 U.S.C. 272(5)), the National Bureau of Standards acts as a sponsor of the National Conference on Weights and Measures in order to promote uniformity among the States in the complex of laws, regulations, methods, and testing equipment that comprises regulatory control by the States of commercial weighing and measuring.

DATE: The meeting will be held July 19-24, 1987.

Location of Meeting: The Excelsior Hotel, Little Rock, Arkansas.

FOR FURTHER INFORMATION CONTACT: Albert D. Tholen, Executive Secretary, National Conference on Weights and Measures, P.O. Box 3137, Gaithersburg, Maryland 20878; telephone: (301-975-4009).

Dated: June 3, 1987.

Ernest Ambler,

Director.

[FR Doc. 87-13162 Filed 6-9-87; 8:45 am]

BILLING CODE 3510-13-M

National Oceanic and Atmospheric Administration

[P8E]

Application for Marine Mammals: Permit; Naval Surface Weapons Center

Notice is hereby given that an Applicant has applied in due form for a Permit to take marine mammals as authorized by the Marine Mammal protection Act of 1972 (16 U.S.C. 1361-1407), and the Regulations Governing the Taking and Importing of Marine Mammals (50 CFR Part 216).

1. Applicant: Naval Surface Weapons Center, Dahlgren, Virginia 22448.

2. Type of Permit: Scientific Research.

3. Name and Number of Marine Mammals:

Pacific Ocean	Number requested
Bottlenose dolphin (*Tursiops truncatus*)	40
Common dolphin (*Delphinus delphis*)	8,000
Northern right whale dolphin (*Lissodelphis borealis*)	500
Pacific white-sided dolphin (*Lagenorhynchus obliquidens*)	40
Grampus (*Grampus griseus*)	50
California sea lion (*Zalophus californianus*)	20
Northern elephant seal (*Mirounga angustirostris*)	15
Pacific harbor seal (*Phoca vitulina richardsi*)	15
Atlantic Ocean	
Bottlenose dolphin (*Tursiops truncatus*)	40

Pacific Ocean	Number requested
Spotted dolphin (*Stenella plagiodon*)	200
Total	8,920

4. Type of Take: The Applicant requests authorization for intentional harassment to devise a means which will evacuate marine mammals from an area in which other activities may cause them harm, and to determine the maximum range at which the SUS Mk 61 Mod 0 and SUS 64 Mod 0 effect the evacuation of the animals.

5. Locations and Periods of Activity:

So. California (San Diego to Santa Catalina Is): Summer 87, 88.

Florida (Cape Canaveral vicinity): Spring 88, 89.

Florida (Key West vicinity): Summer 89.

6. Requested Duration of Permit: 3 yrs.

Concurrent with the publication of this notice in the **Federal Register**, the Secretary of Commerce is forwarding copies of this Application to the Marine Mammal Commission and its Committee of Scientific Advisors.

Written data or views, or requests for a public hearings on this Application should be submitted to the Assistant Administrator for Fisheries, National Marine Fisheries Service, U.S. Department of Commerce, Washington, DC 20235, within 30 days of the publication of this notice. Those individuals requesting a hearing should set forth the specific reasons why a hearing on this particular Application would be appropriate. The holding of such a hearing is at the discretion of the Assistant Administrator for Fisheries.

All statements and opinions contained in this application are summaries of those of the Applicant and do not necessarily reflect the views of the National Marine Fisheries Service.

Documents submitted in connection with the above Application are available for review in the following offices:

Office of Protected Resources and Habitat Programs, National Marine Fisheries Service, 1825 Connecticut Ave., NW., Rm 805, Washington, DC 20009;

Regional Director, Southwest Region, National Marine Fisheries Service, 300 South Ferry Street, Terminal Island, California 90731–7415; and

Regional Director, Southeast Region, National Marine Fisheries Service, 9450 Koger Boulevard, St. Petersburg, Florida 33702.

Dated: June 4, 1987.

Nancy Foster,

Director, Office of Protected Resources and Habitat Programs, National Marine Fisheries Service.

[FR Doc. 87–13204–204 Filed 6–9–87; 8:45 am]

BILLING CODE 3510–22–M

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Import Restraint Limits for Certain Man-Made Fiber Textiles and Textile Products Produced or Manufactured in the People's Republic of Korea

June 5, 1987.

The Chairman of the Committee for the Implementation of Textile Agreements (CITA), under the authority contained in E.O. 11651 of March 3, 1972, as amended, has issued the directive published below to the Commissioner of Customs to be effective on June 11, 1987. For further information contact Eve Anderson, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 377–4212. For information on the quota status of these limits, please refer to the Quota Status Reports which are posted on the bulletin boards of each Customs port or call (202) 566–8041. For information on embargoes and quota re-openings, please call (202) 377–3715.

Background

A CITA directive dated December 23, 1986 (51 FR 47044) established limits for cotton, wool, man-made fiber, silk blend and other vegetable fiber textiles and textile products, produced or manufactured in Korea and exported during the twelve-month period which began on January 1, 1987 and extends through December 31, 1987.

During consulations held on February 2–5, 1987 between the Governments of the United States and the Republic of Korea, agreement was reached to amend the Bilateral Cotton, Wool, Man-Made Fiber, Silk Blend and Other Vegetable Fiber Textile Agreement, effected by exchange of notes dated November 21 and December 4, 1986, to establish sub-limits for Group II Categories 640–D, 640–O and 641 for man-made fiber textile products made from fabric with two or more colors in the warp and/or the filling in Categories 640–DY (dress shirts), 640–OY (other shirts) and 641–Y (blouses), respectively, produced or manufactured in Korea and exported during the period January 1, 1987 through December 31, 1987.

In the letter published below, the Chairman of the Committee for the Implementation of Textile Agreements directs the Commissioner of Customs to prohibit entry into the United States for consumption and withdrawal from warehouse for consumption of man-made fiber textile products in the forgoing categories, produced or manufactured in Korea and exported during the twelve-month period which began on January 1, 1987 and extends through December 31, 1987, in excess of the newly agreed sub-limits.

A description of the textile categories in terms of T.S.U.S.A. numbers was published in the **Federal Register** on December 13, 1982 (47 FR 55709), as amended on April 7, 1983 (48 FR 15175), May 3, 1983 (48 FR 19924), December 14, 1983, (48 FR 55607), December 30, 1983 (48 FR 57584), April 4, 1984 (49 FR 13397), June 28, 1984 (49 FR 26622), July 16, 1984 (49 FR 28754), November 9, 1984 (49 FR 44782), July 14, 1986 (51 FR 25386), July 29, 1986 (51 FR 27068) and in Statistical Headnote 5, Schedule 3 of the TARIFF SCHEDULES OF THE UNITED STATES ANNOTATED (1987).

This letter and the actions taken pursuant to it are not designed to implement all of the provisions of the bilateral agreement, but are designed to assist only in the implementation of certain of its provisions.

Arthur Garel,

Acting Chairman, Committee for the Implementation of Textile Agreements.

June 5, 1987.

Committee for the Implementation of Textile Agreements

Commissioner of Customs,
Department of the Treasury,
Washington, DC 20229.

Dear Mr. Commissioner: This directive amends, but does not cancel, the directive issued to you on December 23, 1986 by the Chairman, Committee for the Implementation of Textile Agreements, concerning imports into the United States of certain cotton, wool, man-made fiber, silk blend and other vegetable fiber textiles and textile products, produced or manufactured in Korea and exported during the twelve-month period which began on January 1, 1987 and extends through December 31, 1987.

Effective on June 11, 1987, the directive of December 23, 1986 is hereby amended to include new sub-limits for man-made fiber textile products in Categories 640–Dy,[1] 640–OY [2] and 641–Y,[3] sublevels of Group II

[1] In Category 640, dress shirts made from fabric with two or more colors in the warp and/or the filling in TSUSA numbers 381.3132 and 381.9i535.

[2] In Category 640, other shirts made from fabric with two or more colors in the warp and/or the filling in TSUSA numbers 381.3142, 381.3152, 381.9547 and 381.9550.

[3] In Category 641, blouses made from fabric with two or more colors in the warp and/or the filling in TSUSA numbers 384.9110 and 384.9120.

Categories 640 -D,[4] 640–O [5] and 641, produced or manufactured in Korea and exported during the twelve-month period which began on January 1, 1987 and extends through December 31, 1987.

Category and New Twelve-Month Limt

649–DY [1]—1,300,000 dozen
640–OY [2]—2,150,000 dozen
641–Y [3]—37,281 dozen

The Committee for the Implementation of Textile Agreements has determined that these actions fall within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

Arthur Garel,

Acting Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 87–13250 Filed 6–9–87; 8:45 am]

BILLING CODE 3510–DR–M

CONSUMER PRODUCT SAFETY COMMISSION

Interagency Committee on Cigarette and Little Cigar Fire Safety; Techncial Study Group Meeting

AGENCY: Interagency Committee on Cigarette and Little Cigar Fire Safety.

ACTION: Notice of meeting.

SUMMARY: The Technical Study Group on Cigarette and Little Cigar Fire Safety will meet on June 29 and 30, 1987, in Washington, DC to review the technical reports implementing the Cigarette Safety Act of 1984.

DATE: The meeting will be on June 29 and 30, 1987, from 9:30 a.m. to 5:00 p.m. each day.

ADDRESS: The meeting will be in the first floor auditorium of the Hubert Humphrey Building, 200 Independence Avenue, SW., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Ms. Terri Buggs, Office of Program Management and Budget, Consumer Product Safety Commission, Washington, DC 20207; telephone (301) 492–6554.

SUPPLEMENTARY INFORMATION: The Cigarette Safety Act of 1984 (Pub. L. 98–567, 98 Stat. 2925, October 30, 1984) created the Technical Study Group on Cigarette and Little Cigar Fire Safety to prepare a final technical report to Congress concerning the technical and commercial feasibility of developing cigarettes and little cigars with minimum propensity to ignite upholstered furniture and mattresses.

The Technical Study Group will meet on June 29 and 30, 1987, to review technical reports on the following topics: (1) Cigarette ignition propensity measurement; (2) benefit-cost analysis; (3) ignition probability analysis; (4) pilot field data study; and (5) cigarette performance data study.

The meeting will be open to observation by members of the public, but only members of the Technical Study Group may participate in the discussion.

Dated: May 29, 1987.

Colin B. Church,

Federal Employee Designated by the Interagency Committee on Cigarette and Little Cigar Fire Safety.

[FR Doc. 87–13193 Filed 6–9–87; 8:45 am]

BILLING CODE 6355–01–M

DEPARTMENT OF DEFENSE

Office of the Secretary

Education Benefits Board of Actuaries: Meeting

AGENCY: Department of Defense Education Benefits Board of Actuaries.

ACTION: Notice of meeting.

SUMMARY: A meeting of the Board has been scheduled to execute the provisions of Chapter 101, title 10, United States Code (10 U.S.C. 2006(e) et. seq.). The Board shall review DoD actuarial methods and assumptions to be used in the valuation of the GI Bill and determine per capita normal costs to be implemented bvy DoD in FY88. Persons desiring to attend the DoD Education Benefits Board of Actuaries meeting must notify Ms. Dorothy Hemby at 696–6336 by July 10, 1987. Notice of this meeting is required under the Federal Advisory Committee Act.

DATE: July 13, 1987, 1:00 p.m. to 5:00 p.m..

ADDRESS: Room 1E801 (#7), the Pentagon (River Entrance).

FOR FURTHER INFORMATION CONTACT: Toni Hustead, Executive Secretary, DoD Office of the Actuary, 4th Floor, 1600 Wilson Boulevard, Arlington, Virginia 22209–2593, (202) 696–5869.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

June 5, 1987.

[FR Doc. 87–13181 Filed 6–9–87; 8:45 am]

BILLING CODE 3810–01–M

Retirement Board of Actuaries; Meeting.

AGENCY: Department of Defense Retirement Board of Actuaries.

ACTION: Notice of Meeting.

SUMMARY: A meeting of the Board has been scheduled to execute the provisions of chapter 74, title 10, United States Code (10 U.S. 1461 et. seq.). The Board shall (1) review the September 30, 1986 valuation results; (2) determine actuarial assumptions for the September 30, 1987 valuation; and (3) authorize the October 1, 1987 unfunded liability payment. Persons desiring to attend the DoD Retirement Board of Actuaries meeting must notify Ms. Dorothy Hemby at (202) 696–6336 by July 10, 1987. Notice of this meeting is required under the Federal Advisory Committee Act.

DATE: July 14, 1987, 9:00 a.m. to Noon.

ADDRESS: Room 1E801 (#7), the Pentagon (River Entrance).

FOR FURTHER INFORMATION CONTACT: Toni Hustead, Executive Secretary, DoD Office of the Actuary, 4th Floor, 1600 Wilson Boulevard, Arlington, Virginia 22209–2593, (202) 696–5869.

Patricia H. Means,

OSD Federal Register, Liaison Officer, Department of Defense.

June 5, 1987.

[FR Doc. 87–13182 Filed 6–9–87; 8:45am]

BILLING CODE 3810–01–M

Strategic Defense Initiative Advisory Committee; Meetings

ACTION: Notice of Advisory Committee Meetings,

SUMMARY: The Strategic Defense Initiative (SDI) Advisory Committee will meet in closed session in Washington, DC, on July 7-9, 1987.

The mission of the SDI Advisory Committee is to advise the Secretary of Defense and the Director, Strategic Defense Initiative Organization on scientific and technical matters as they affect the perceived needs of the Department of Defense. At the meeting on July 7-9, 1987 the committee will discuss status of SDI research and management issues.

In accordance with section 10(d) of the Federal Advisory Committee Act, Pub. L. No. 92–463, as amended (5 U.S.C., App II, (1982)), it has been determined that this SDI Advisory Committee meeting, concerns matters listed in 5 U.S.C., 552b(c)(1) (1982), and that accordingly this meeting will be closed to the public.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

June 5, 1987.

[FR Doc. 87–13183 Filed 6–9–87; 8:45a m]

BILLING CODE 3810–01–M

[4] In Category 640, dress shirts only in TSUSA numbers 381.3132, 381.3134, 381.9534, 381.9535, 381.9540, 381.9968, 381.8666, 381.6972 and 381.3558.

[5] In Category 640, other shirts in all TSUSA numbers except 381.3132, 381.3134, 381.9535, 381.9540, 381.9968, 381.8666, 381.6972 and 381.3558.

Department of the Army

Intent To prepare a Draft Environmental Impact Statement (EIS) for the Shore and Barrier Island Erosion Interim study of the Louisiana Coastal Area, Louisiana Study

AGENCY: U.S. Army Corps of Engineers, DOD, New Orleans District.

ACTION: Notice of Intent ot prepare a Draft EIS.

SUMMARY: 1. *Proposed Action.* The study purpose is to determine the advisability of improvements or modification of existing improvements in the Louisiana coastal area with the intent of shore and barrier island erosion control. The study was authorized by a resolution adopted by the Senate Committee on Public Works on 19 April 1967, and the House Committee on Public Works on 19 October 1967, and examines about 810 miles of gulf shoreline and approximately 100 miles of barrier islands. The shorelines and barrier islands were found to be receding up to 55 feet per year and coastal marshes behind these lands were being converted to open water at a rate of about 39 square miles each year. A reduction in the erosion process would slow the loss of fish and wildlife habitat and resources, reduce hurricane induced storm damage, assist in the economic stability of coastal communities, and preserve the unique cultural and historical heritage of southern Louisiana.

From previous studies, four segments of coastal shoreline and barrier islands were determined to warrant evaluation. These segments were Grand Terre Island to Shell Island, the vicinity of Holly Beach, Fourchon to Camada Beach, and Terrebonne Parish Barrier Islands. The environmental impacts of improvements to each segment will be evaluated in a separate Environmental Impact Statement (EIS). The EIS currently in preparation inolves the beach segment from the western end of Grand Terre to Shell Island, Plaquemines Parish, Louisiana.

2. *Alternatives.* Alternatives under consideration for the project include, individually or in combination, revetments, creative use of dredge material, beach nourishment, construction of artificial sandbars, planting vegetation, sand fencing, breakwaters, dune construction, dikes, and elevated walkways. The no action alternative would result in no additional erosion protection, and is the basis of comparison for the alternative plans examined.

3. *Scoping Process.* a. Public meetings were held on August 27, 1984, in New Orleans, August 28, 1984 in Houma, and August 30, 1984 in Cameron, Louisiana, to discuss the views of the local interest concerning shore and barrier island erosion. Inter-agency scoping meetings have been conducted with the U.S. Fish and Wildlife Service, Soil Conservation Service, Louisiana Geological Survey, and the Lousiana Department of Natural Resources. The public involvement program will also include a scoping letter and meetings to obtain input as to alternatives under consideration and significant resources to be evaluated in the EIS. The participation of affected Federal, state, and local agencies, and other interested private organizations and parties will be invited.

b. Singificant issues to be analyzed in the EIS include impacts of the proposed changes on biological, cultural, historical, social, economic, water quality, and human resources, and project costs.

c. The U.S. Fish and Wildlife Services will provide Planning Aid information and a Coordination Act Report for the draft EIS.

d. The draft EIS will be coordinated with all required Federal, state, and local agencies, environmental groups, landowner groups, and intested individuals. All review comments received will be considered and responses will be made.

4. *Public Meeting(s).* Public meetings were initially conducted in 1968, and recent meetings were held in August 1984, in New Orleans, Houma, and Cameron, Louisiana; to inform the public about this project. Intra-agency meetings of concerned Federal and state natural resource agencies have been conducted since 1968, and additional meetings with these agencies will follow.

5. *Availability.* The draft EIS is scheduled to be available to the public in early 1988.

ADDRESS: Questions concerning the proposed action and draft EIS may be directed to Mr. E. Scott Clark, U.S. Army Corps of Engineers, Environmental Quality Section (LMNPD-RE), P.O. Box 60267, New Orleans, Louisiana 70160–0267, telephone (504) 862–2521.

Dated: June 1, 1987.

Lloyd K. Brown,

Colonel, Corps of Engineers District Engineer.

FR Doc. 87–13150 Filed 6–9–87;8:45am]

BILLING CODE 2710–84–M

Army Science Board, Closed Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), announcement is made of the following committee meeting:

Name of Committee: Army Science Board (ASB).

Date of Meeting: 30 June 1987.

Time of Meeting: 0800–1500 hours

Place: Atomspheric Science Lab, White Sands Missile Range, NM.

Agenda: The Subpanel on Natural Environment of the Army Science Board Summer Study Panel for Army Force Cost Drivers will visit the Atmospheric Sciences Laboratory (ASL) and Vulnerability Assessment Laboratory (VAL). The meeting at ASL is to learn how the natural environmental specifications are derived for weapon systems and how they are validated as necessary to mission success of the weapons system. This meeting will be closed to the public in accordance with section 552b(c) of Title 5, U.S.C., specifically subparagraph (1) thereof, and Title 5, U.S.C., Appendix 1, subsection 10(d). The classified and unclassified matters and proprietary information to be discussed are so inextricably intertwined so as to preclude opening and portion of the meeting. Contact the Army Science Board Administrative Officer, Sally Warner, for further information at (202) 695–7046.

Sally A. Warner,

Administrative Officer, Army Science Board.

[FR Doc. 87–13258 Filed 6–9–87; 8:45 am]

BILLING CODE 3710–08–M

DEPARTMENT OF ENERGY

Liquefied Gaseous Fuels Spill Test Facility

In accordance with the Congressional action on the Continuing Resolution (Pub. L. 97–377), the Department of Energy (DOE), in support of the Fossil Energy Liquefied Gaseous Fuels Spill Test Facility Program, is setting forth this notice that the Spill Test Facility is available for user-sponsored spill testing. The facility, which is located at the Department's Nevada Test Site (NTS), Mercury, Nevada, has recently undergone extensive readiness confirmation trials. It is capable of the rapid release of large quantities of cryogenic, flammable, or toxic materials, and was built in concert with and in response to the needs of many industrial and government organizations. To that end, the facility has been designed to reproduce the size and rate of accidental releases as closely as possible with the actual materials of concern.

It can (1) discharge, at a controlled rate, a known amount of hazardous test fluid; (2) monitor and record process operating data, meteorological data, downwind gas concentration data, and other data as is required for the experiment; and (3) provide a means to

control and monitor these functions from a remote location.

The NTS and the surrounding Nellis Air Force Range is remote and not open to public access. The area downwind of the spill facility is essentially unpopulated with access strictly controlled all the way to the Nellis boundary 60 km (37 miles) away.

In conjunction with this notice, the DOE is inviting industry and Federal agency representatives who have an interest in the Liquefied Gaseous Fuels Spill Test Facility to attend a user-oriented forum which will be held July 23, 1987, in Las Vegas, Nevada. It is the intent of the Department to provide attendees the opportunity to discuss facility operations policy and procedures and to explore details with potential partners regarding a number of issues on the subject of cooperative cost-shared research and development ventures with the U.S. private sector, states and/or other interested participants. A tour of the Spill Test Facility is also planned.

For Further Information Contact: Mr. J. E. Walsh, Jr., Deputy Assistant Secretary for Management, Fundamental Research and Cooperative Development, Office of Fossil Energy, U.S. Department of Energy, FE-10, GTN, Washington, DC 20545.

Issued in Washington, DC, on May 29, 1987.

J. Allen Wampler,

Assistant Secretary, Fossil Energy.

[FR Doc. 87-13261 Filed 6-9-87; 8:45 am]

BILLING CODE 6450-01-M

Economic Regulatory Administration

[ERA Docket No. 87-24-NG]

Cherhill Resources Inc.; Application To Import Natural Gas From Canada

AGENCY: Economic Regulatory Administration, DOE.

ACTION: Notice of Application for Blanket Authorization to Import Natural Gas from Canada.

SUMMARY: The Economic Regulatory Administration (ERA) of the Department of Energy (DOE) gives notice of receipt on May 5, 1987, of an application from Cherhill Resources Inc. (Cherhill) for blanket authorization to import Canadian natural gas for short-term and spot market sales to customers in various markets in the United States. Authorization is requested to import up to 137 MMcf per day and up to 100 Bcf over a two-year term beginning on the date of the first delivery. Cherhill, a Nevada Corporation with its principal place of business in Reno, Nevada, is a wholly owned subsidiary of Cherhill Resources Limited. Cherhill proposes to purchase natural gas from its Canadian affiliate and from various other Canadian suppliers on a short-term basis, for its own account and for the account of others, for resale to local distribution companies, pipelines, and industrial and commercial end users in the United States. Cherhill intends to use existing pipeline facilities for the transportation of the proposed imports. Cherhill will advise the ERA of the date of first delivery of the import and submit quarterly reports giving details of individual transactions.

The application is filed with the ERA pursuant to section 3 of the Natural Gas Act and DOE Delegation Order No. 0204-111. Protests, motions to intervene, notices of intervention and written comments are invited.

DATE: Protests, motions to intervene, or notices of intervention, as applicable, and written comments are to be filed no later than July 10, 1987.

FOR FURTHER INFORMATION:

Robert M. Stronach, Natural Gas Division, Economic Regulatory Administration, Forrestal Building, Room GA-076, 1000 Independence Avenue, SW., Washington, DC 20585 (202) 586-9622;

Diane J. Stubbs, Natural Gas and Mineral Leasing, Office of General Counsel, U.S. Department of Energy, Forrestal Building, Room 6E-042, 1000 Independence Avenue, SW., Washington, DC 20585 (202) 586-6667.

SUPPLEMENTARY INFORMATION: The decision on this application will be made consistent with the DOE's gas import policy guidelines, under which the competitiveness of an import arrangement in the markets served is the primary consideration in determining whether it is in the public interest (49 FR 6684, February 22, 1984). Parties that may oppose this application should comment in their responses on the issue of competitiveness as set forth in policy guidelines. The applicant asserts that this import arrangement is competitive. Parties opposing the arrangement bear the burden of overcoming this assertion.

Public Comment Procedures

In response to this notice, any person may file a protest, motin to intervene or notice of intervention, as applicable, and written comments. Any person wishing to become a party to the proceeding and to have the written comments considered as the basis for any decision on the application must, however, file a motion to intervene or notice of intervention, as applicable. The filing of a protest with respect to this application will not serve to make the protestant a party to the proceeding, although protests and comments received from persons who are not parties will be considered in determining the appropriate procedural action to be taken on the application. All protests, motions to intervene, notices of intervention, and written comments must meet the requirements that are specified by the regulations in 10 CFR Part 590. They should be filed with the Natural Gas Division, Office of Fuels Programs, Economic Regulatory Administration, Room GA-076, RG-23, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-9478. They must filed no later than 4:30 p.m. e.d.t., July 10, 1987.

The Administrator intends to develop a decisional record on the application through responses to this notice by parties, including the parties' written comments and replies thereto. Additional procedures will be used as necessary to achieve a complete understanding of the facts and issues. A party seeking intervention may request that additional procedures be provided, such as additional written comments, an oral presentation, a conference, or a trial-type hearing. A request to file additional written comments should explain why they are necessary. Any request for an oral presentation should identify the substantial question of fact, law, or policy at issue, show that it is material and relevant to a decision in the proceeding, and demonstrate why an oral presentation is needed. Any request for a conference should demonstrate why the conference would materially advance the proceeding. Any request for a trial-type hearing must show that there are factual issues genuinely in dispute that are relevant and material to a decision and that a trial-type hearing is necessary for a full and true disclosure of the facts.

If an additional procedure is scheduled, the ERA will provide notice to all parties. If no party requests additional procedures, a final opinion and order may be issued based on the official record, including the application and responses filed by parties pursuant to this notice, in accordance with 10 CFR 590.316.

A copy of Cherhill's application is available for inspection and copying in the Natural Gas Division Docket Room, GA-076-A, at the above address. The docket room is open between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC, May 28, 1987.

Constance L. Buckley,

Director, Natural Gas Division, Office of Fuels Programs, Economic Regulatory Administration.

[FR Doc. 87-13199 Filed 6-9-87; 8:45 am]

BILLING CODE 6450-01-M

[ERA Docket No. 87-01-NG]

Quintana Minerals Corp.; Order Granting Blanket Authorization To Import Natural Gas From Canada

AGENCY: Economic Regulatory Administration, DOE.

ACTION: Notice of Application for Blanket Authorization To Import Natural Gas from Canada.

SUMMARY: The Economic Regulatory Administration (ERA) of the Department of Energy (DOE) gives notice that it has issued an order granting Quintana Minerals Corporation (QMC) blanket authorization to import natural gas from Canada. The order issued in ERA Docket No. 87-01-NG authorizes QMC to import up to 40 Bcf over a two-year period for sale in the domestic spot market.

A copy of this order is available for inspection and copying in the Natural Gas Division Docket Room, GA-076, Forrestal Building, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586-9478. The docket room is open between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday, except Federal holidays.

Issued in Washington, DC, June 3, 1987.

Constance L. Buckley,

Director, Natural Gas Division, Office of Fuels Programs, Economic Regulatory Administration.

[FR Doc. 87-13200 Filed 6-9-87; 8:45 am]

BILLING CODE 6450-01-M

Proposed Remedial Order to Merit Petroleum, Inc., Thomas H. Battle, and Anton E. Meduna

AGENCY: Economic Regulatory Administration, DOE.

ACTION: Notice of Proposed Remedial Order to Merit Petroleum, Inc., Thomas H. Battle, and Anton E. Meduna.

SUMMARY: Pursuant to 10 CFR 205.192(c), the Economic Regulatory Administration of the United States Department of Energy hereby gives notice of a Proposed Remedial Order which was issued to Merit Petroleum, Inc. and Thomas H. Battle, 2802 Valley Way, Kingwood, Texas 77339, and Anton E. Meduna, 10846 Pepper, Spring Branch, Texas 77079. This Proposed Remedial Order alleges violations in the amount of $48,290,793.17, plus interest, resulting from violations of 10 CFR 212.186, 10 CFR 205.202 and 10 CFR 210.62(c) during the period November 1978 through December 1980. The effect of the alleged violations is nationwide.

A copy of Proposed Remedial Order may be obtained from: Office of Freedom of Information Reading Room, United States Department of Energy, Forrestal Building, Room 1E-190, 1000 Independence Avenue, SW., Washington, DC 20585.

Within fifteen (15) days of publication of this Notice, any aggrieved person may file a Notice of Objection with the Office of Hearings and Appeals, United States Department of Energy, Forrestal Building, Room 6F-078, 1000 Independence Avenue, SW., Washington, DC 20585, in accordance with 10 CFR 205.193. The Notice shall be filed in duplicate, shall briefly describe how the person would be aggrieved by issuance of the Proposed Remedial Order as a final order and shall state the person's intention to file a Statement of Objections.

Pursuant to 10 CFR 205.193(c), a person who files a Notice of Objection shall on the same day serve a copy of the Notice upon:

Sandra K. Webb, Director, Economic Regulatory Administration, U.S. Department of Energy, One Allen Center, Suite 610, 500 Dallas Street, Houston, Texas 77002

and upon:

Marshall A. Staunton, Administrator, Economic Regulatory Administration, U.S. Department of Energy, Room 3H-017, RG-40, 1000 Independence Avenue, SW., Washington, DC 20585

Issued in Washington, DC on June 2, 1987.

Marshall A. Staunton,

Administrator, Economic Regulatory Administration.

[FR Doc. 87-13201 Filed 6-9-87; 8:45 am]

BILLING CODE 6450-01-M

Federal Energy Regulatory Commission

[Docket No. G-4616-002, et al.]

Texaco Inc. et al.; Applications for Certificates, Abandonments of Service and Petitions to Amend Certificates [1]

June 4, 1987.

Take notice that each of the Applicants listed herein has filed an application or petition pursuant to section 7 of the Natural Gas Act for authorization to sell natural gas in interstate commerce or to abandon service as described herein, all as more fully described in the respective applications and amendments which are on file with the Commission and open to public inspection.

Any person desiring to be heard or to make any protest with reference to said applications should on or before June 18, 1987, file with the Federal Energy Regulatory Commission, Washington, DC 20426, petitions to intervene or protests in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.211, .214). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Persons wishing to become parties to a proceeding or to participate as a party in any hearing therein must file a petition to intervene in accordance with the Commission's rules.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Applicants to appear or to be represented at the hearing.

Kenneth F. Plumb,

Secretary.

[1] This notice does not provide for consolidation for hearing of the several matters covered herein.

Docket No. and date filed	Applicant	Purchaser and Locations	Price per Mcf	Pressure base
G-4616-002, D, May 7, 1987	Texaco Inc., P.O. Box 52332, Houston, Texas 77052.	K N Energy, Inc., Guymon-Hugoton Field, Texas County, Oklahoma.	(1)	
CI87-576-000, F, May 7, 1987	Texaco Producing Inc. (Succ. in Interest to Texaco Inc.), P.O. Box 52332, Houston, Texas 77052.	do	(2)	

Docket No. and date filed	Applicant	Purchaser and Locations	Price per Mcf	Pressure base
G-12568-001, D, May 7, 1987.	Texaco Inc	K N Energy, Inc., Camrick Field, Texas County, Oklahoma.	(1)	
CI87-575-000, F, May 7, 1987.	Texaco Producing Inc. (Succ. in Interest to Texaco Inc.).	do	(2)	
CI64-196-001, D, May 6, 1987.	Texaco Inc	Panhandle Eastern Pipe Line Company, Mouser Field, Texas County, Oklahoma.	(1)	
CI87-571-000, F, May 6, 1987.	Texaco Producing Inc. (Succ. in Interest to Texaco Inc.).	do	(2)	
CI87-573-000 (CI83-267), B, May 6, 1987.	Texaco Producing Inc	Southern Natural Gas Company, Eugene Island Block 260, Offshore Louisiana.	(4)	
CI63-79-001, D, May 8, 1987	do	Panhandle Eastern Pipeline Company, Iuka-Carmi Field, Pratt County, Kansas.	(5)	
CI63-79-002, D, May 11, 1987.	do	do	(6)	
CI87-574-000 (CI73-21), B, May 6, 1987.	Texaco Inc	Southern Natural Gas Company, Eugene Island Block 275, Offshore Louisiana.	(7)	
CI87-591-000, F, May 14, 1987.	Texaco Inc. (Succ. In Interest to Sun Exploration and Production Company).	United Gas Pipe Line Company, North Boyce Field, Goliad County, Texas.	(8)	
CI87-577-000, B, May 7, 1987.	Texaco Producing Inc	Phillips Petroleum Company, Eunice Plant and Skaggs Drinkard Field, Lea County, New Mexico.	(9)	
CI66-176-002, D, May 18, 1987.	do	Arkla Energy Resources, Arkoma Area, Various Counties in Arkansas and Oklahoma.	(10)	
G-4918-001, D, May 18, 1987.	Sun Exploration & Production Co., P.O. Box 2880, Dallas, Texas 75221-2880.	Phillips Petroleum Company, Panhandle Field, Moore County, Texas.	(11)	
CI61-1429-010, D, May 13, 1987.	do	El Paso Natural Gas Company, Jalmat et al. Fields, Lea County, New Mexico.	(12)	
CI62-1251-008, D, May 14, 1987.	do	Arkansas Louisiana Gas Company, Wilburton Field, Latimer County, Oklahoma.	(13)	
CI73-55-000, D, May 14, 1987.	do	Arkansas Louisiana Gas Company, West Wilburton Field, Pittsburg County, Oklahoma.	(14)	
G-13634-004, D, May 14, 1987.	do	Northern Natural Gas Company, Division of Enron Corp., N.W. Dower Field, Beaver County, Oklahoma.	(15)	
G-4684-000, D, May 14, 1987.	do	Colorado Interstate Gas Company, Keyes Field, Cimarron County, Oklahoma.	(16)	
G-4917-000, D, May 14, 1987.	do	Transcontinental Gas Pipe Line Corp., South Mineral Field, Bee County, Texas.	(17)	
G-15791-003, D, May 18, 1987.	do	Transwestern Pipeline Company, Feldman & Hansford Fields, Hemphill & Hansford Counties, Texas.	(18)	
CI87-610-000 (CI68-1411), B, May 20, 1987.	Union Texas Petroleum Corp., P.O. Box 2120, Houston, Texas 77252-2120.	Transcontinental Gas Pipe Line Corp., Block 66 Field, South Marsh Island Area, Offshore Louisiana.	(19)	
CI87-609-000 (CI71-798), B, May 20, 1987.	do	Transcontinental Gas Pipe Line Corp., West Tuleta Field, Bee County, Texas.	(19)	
CI87-600-000 (G-6223), B, May 19, 1987.	do	Arkansas Louisiana Gas Company, Thomas Lease, Chickasha Field, Grady County, Oklahoma.	(19)	
CI87-599-000 (G-6222), B, May 19, 1987.	do	Arkansas Louisiana Gas Company, Scott Lease, Chickasha Field, Grady County, Oklahoma.	(19)	
CI87-612-000 (G-8298), B, May 21, 1987.	do	United Gas Pipe Line Company, North Pettus & Burnell Fields, Bee, Goliad and Karnes Counties, Texas.	(19)	
CI87-601-000 (CI66-621), B, May 19, 1987.	Union Texas Petroleum Corp	United Gas Pipe Line Company, Abbeville Field, Vermilion Parish, Louisiana.	(19)	
CI87-606-000 (CI61-1275), May 19, 1987.	do	Natural Gas Pipe Line Company of America, Boyd Miller Unit, North Custer City Field, Custer County, Oklahoma.	(19)	
CI87-607-000 (G-4659), B, May 19, 1987.	do	Texas Eastern Transmission Corporation, Balser Unit, San Domingo Field, Bee County, Texas.	(19)	
CI87-608-000 (CI65-381), May 19, 1987.	do	Northern Natural Gas Company, Division of Enron Corp., Gate Lake Field, Harper County, Oklahoma.	(19)	
CI87-613-000 (G-4656), B, May 19, 1987.	do	Texas Eastern Transmission Corporation, Strauch-Wilcox Field, Bee County, Texas.	(19)	

Docket No. and date filed	Applicant	Purchaser and Locations	Price per Mcf	Pressure base
G-13385-000, D, May 15, 1987.	ARCO Oil and Gas Company, Division of Atlantic Richfield Company, P.O. Box 2819.	Northern Natural Gas Company, Division of Enron Corp., Hugoton Field, Finney County, Kansas.	(19)	
G-2897-000, D, May 15, 1987.	....do....	Colorado Interstate Gas Company, Hugoton Field, Grant and Kearney Counties, Kansas.	(20)	
CI65-1267-000, D, May 15, 1987.	....do....	El Paso Natural Gas Company, Hugoton Field, Stevens and Grant Counties, Kansas.	(20)	
CI66-572-001, D, May 15, 1987.	....do....	K N Energy, Inc., Beauchamp Field, Stanton County, Kansas.	(20)	
CI77-790-001, D, May 7, 1987.	....do....	Northwest Pipeline Corporation, South Baxter Pass Field, Rio Blanco and Garfield Counties, Colorado.	(21)	
CI62-531-001, D, May 7, 1987.	....do....	Northern Natural Gas Company, Division of Enron Corp., Sitka Field, Clark County, Kansas.	(21)	
G-17979-002, D, May 7, 1987.	....do....	Transwestern Pipeline Company, Kiowa Creek and Follett Fields, Lipscomb County, Texas.	(21)	
CI62-105-001, D, May 4, 1987.	....do....	Northern Natural Gas Company, Division of Enron Corp., N. Harper Ranch and Sitka Fields, Clark County, Kansas.	(21)	
G-12886-000, D, May 18, 1987.	Kerr-McGee Corporation, P.O. Box 25861, Oklahoma City, Okla. 73125.	ANR Pipeline Company, Laverne Field, Harper County, Oklahoma.	(22)	
G-2758-000, —, May 18, 1987.	....do....	Northern Natural Gas Company, Division of Enron Corp. Pampa Gas Processing Plant, Gray County, Texas.	(23)	
CI87-602-000 (CI75-279), B, May 18, 1987.	....do....	Tennessee Gas Pipeline Company, Vermilion Area Block 39 S/2 OCS-G-0341, Gulf of Mexico, State of Louisiana.	(24)	
CI67-1533-001, D, May 18, 1987.	....do....	Texas Eastern Transmission Corporation, Coteau Frene Field, Assumption Parish, Louisiana.	(25)	
CI67-1602-003, D, May 14, 1987.	BHP Petroleum (Americas) Inc., 5847 San Felipe—Suite 3600, Houston, Texas 77057.	United Gas Pipe Line Company, Bayou St. Vincent Field, Assumption Parish, Louisiana.	(26)	
CI87-592-000 (CI68-42), B, May 14, 1987.	....do....	ANR Pipeline Company, Woodward Area, Woodward County, Oklahoma.	(27)	
CI72-595-000, B, May 18, 1987.	Phillips 66 Natural Gas Company, 990-G Plaza Office Building, Bartlesville, Okla. 74004.	El Paso Natural Gas Company, Tailgate of Fullerton Plant, Andrews County, Texas.	(28)	
G-2605-001, B, May 18, 1987.	....do....	....do....	(28)	
CI68-894-003, D, May 14, 1987.	Union Oil Company of California P.O. Box 7600, Los Angeles, Calif. 90051.	Panhandle Eastern Pipe Line Company, Putnam Field, Dewey County, Oklahoma.	(29)	
CI87-598-000 (CI82-74-000), B, May 18, 1987.	TXO Production Corp., First City Center, LB 10, 1700 Pacific Avenue, Dallas, Texas 75201-4696.	Panhandle Eastern Pipe Line Company, Sec. 31-T32S-R43W, Baca County, Colorado.	(30)	
CI87-597-000 (CI82-73-000), B, May 18, 1987.	....do....	Panhandle Eastern Pipe Line Company, Sec. 30-T32S-R43W, Baca County, Colorado.	(31)	
G-6352-002, D, May 20, 1987.	Conco Inc., P.O. Box 2197, Houston, Texas 77252.	United Gas Pipe Line Company, Cabeza Creek Field, Goliad and DeWitt Counties, Texas.	(32)	
C187-593-000, B, May 11, 1987.	Graham-Michaelis Drilling Co. Inc., P.O. Box 247, Wichita, Kansas 67201.	Northern Natural Gas Company, Division of Enron Corp., Sitka Morrow Gas Pool, Clark County, Kansas.	(33)	
C187-97-001, D, May 15, 1987.	ENSTAR Corporation, P.O. Box 2120, Houston, Texas 77252-2120.	Transcontinental Gas Pipe Line Corp., West Cameron Block 41, Offshore Louisiana.	(34)	
C187-603-000, B, May 18, 1987.	John Q. McCabe, P.O. Box 10528, Midland, Texas 79702.	Farmland Industries, Inc., South Half of Section 24, Block TT, T.C.R.R. Survey, Schleicher County, Texas.	(35)	
C187-596-000 (C167-1074), B, May 18, 1987.	The Parade Company, 425 Edwards Street—Suite 1308, Shreveport, La. 71101.	United Gas Pipe Line Company, Parade's Giles Gas Plant, M.J. Pru Survey A-29, Rusk County, Texas.	(36)	
C187-585-000, B, May 7, 1987.	Gypsy Drilling Co., Inc., Box 2558, Hutchinson, Kansas 67504-2558.	Williams Natural Gas Company, Palmer Field, Barber County, Kansas.	(37)	

Docket No. and date filed	Applicant	Purchaser and Locations	Price per Mcf	Pressure base
C187-614-000 (C172-298), B, May 21, 1987.	Exxon Corporation, P.O. Box 2180, Houston, Texas 77252-2180.	Mississippi River Transmission Corp., Woodlawn Field, Harrison County, Texas.	[38]	
C187-580-000, B, May 11, 1987.	J. Cleo Thompson and James Cleo Thompson, Jr., 4500 Republic Bank Tower, Dallas, Texas 75201.	El Paso Natural Gas Company, Parker-Harrell Field, Crockett County, Texas.	[39]	
C187-582-000, B, May 12, 1987.	Mahada Energy Corp., 2001 Kirby Drive—Suite 1006, Houston, Texas.	Natural Gas Pipeline Company of America, Fairbanks Field, Harris County, Texas.	[40]	
C187-440-000, B, April 7, 1987.	Expando Production Company, P.O. Drawer 8246, Wichita Fallas, Texas 76307.	ANR Pipeline Company, South Elton Field, Jefferson Davis Parish, Louisiana.	[41]	
C187-441-000, B, April 7, 1987.	.....do.....	United Gas Pipe Line Company, South Elton Field, Jefferson Davis Parish, Louisiana.	[47]	
C177-345-003, D, May 22, 1987.	Amoco Production Company, P.O. Box 50879, New Orleans, La. 70150.	Sea Robin Pipeline Company, South Marsh Island Block 128 Field, Offshore Louisiana.	[42]	
C173-135-001, D, May 22, 1987.	.....do.....	Columbia Gas Transmission Corporation, East Cameron Block 33 Field, Offshore Louisiana.	[43]	
C187-620,000 (G-6295), B, May 22, 1987.	J.M. Huber Corporation, 2000 West Loop South, Houston, Texas 77027.	Panhandle Eastern Pipe Line Company, Panhandle Field, Hutchinson and Carson Counties, Texas.	[44]	
C181-311-001, D, May 26, 1987.	Texaco Producing Inc	El Paso Natural Gas Company, Jalmat-Yates Field, Lea County, New Mexico.	[45]	
C167-1006-000, D, May 26, 1987.	Texaco Producing Inc	Transwestern Pipeline Company, Halley Field Winkler County, Texas.	[46]	
C187-560-000, B, May 4, 1987 [49].	Mountain States Petroleum Corp., Roswell, New Mexico 88201.	El Paso Natural Gas Company, Sec. 20-T15S-R28E and Sec. 36-T14S-R27E, Chaves County, New Mexico.	[48]	
C187-594-000, B, May 11, 1987.	Tamarack Petroleum Company, Inc., 1485 One First City Center, Midland, Texas 79701.	Northern Natural Gas Company, Sec. 14, Block R, G.H. Murray Survey, Crockett County, Texas.	[50]	
C187-534-000, B, May 27, 1987 [51].	Hamon Operating Compnay, 325 N. St. Paul Street—Suite 3900, Dallas, Texas 75201-3902.	El Paso Natural Gas Company, Carlsbad Field, Eddy County, New Mexico.	[52]	
C187-553-000, B, April 30, 1987 [53].	Hondo Oil and Gas Company, P.O. Box 11248, Midland, Texas 79702.	Mountain Resources, Inc., Jake Shaeffer No. 1, Mam Creek Field, Sec. 12-R93W-T7S, Garfield County, Colorado.	[54]	
C187-616-000, D, May 21, 1987.	Tenneco Oil Company, P.O. Box 2511, Houston, Texas 77001.	Williams Natural Gas Company, Wakita Trend Field, Grant County, Oklahoma.	[55]	
C187-624-000, A, May 26, 1987.	Cities Service Oil and Gas Corporation, P.O. Box 300, Tulsa, Okla. 74102.	Texas Eastern Transmission Corporation, West Cameron Block 459 Well No. 3, Offshore Louisiana.	[56]	
C187-633-000, B, May 26, 1987.	Horizon Oil & Gas Co. of Texas, P.O. Box 1020, Dallas, Texas 75221.	Northern Natural Gas Company, Dodson Lease, Cleveland Field, Ochiltree County, Texas.	[57]	
C187-634-000, B, May 26, 1987.	.....do.....	Northern Natural Gas company, Dodson Lease, Cleveland Field, Ochiltree County, Texas.	[57]	
C187-545-000, B, May 27, 1987.	Gruss Petroleum Corp., 407 N. Big Spring—Suite 200, Midland, Texas 79701.	El Paso Gas Company, Sprayberry Trend Area, Upton County, Texas.	[58]	
C187-556-000, B, May 1, 1987.	Chevron U.S.A. Inc., P.O. Box 7309, San Francisco, Calif. 94120-7309.	Mountain Fuel Resources, Inc., Spearhead Ranch Field, Converse County, Wyoming.	[59]	
C187-647-000, F, May 27, 1987.	Exxon Corporation	Northern Natural Gas Company, W. Arthur Gray Unit, Camerick Field, Beaver County, Oklahoma.	[60]	

[1] Assignment of a part of Texaco Inc.'s interest to Texaco Producing Inc.

[2] Effective 12-31-84, Applicant acquired by Assignment an interest of Texaco Inc. of certain properties in Texas County, Oklahoma.

[3] Not used.

[4] By assignment dated 12-3-86, effective 8-8-86, Texaco Producing Inc. assigned to Huffco Petroleum Corporation its right, title, and interest in and to Eugene Island Block 260, SE ¼, OCS-G-1891, Offshore Louisiana.

[5] By Assignment executed on 3-31-87, but effective 8-1-86, Texaco Producing Inc. assigned to Helmke/Carmi Venture Partnership its right, title, and interest in and to the following described properties in Pratt County, Kansas: N/2 NE/4 SW/4 NE/4 and SE/4 of Section 6; Lots 1, 2, 3, & 4, E/2 NW/4 W/2 NE/4, E/2 SW/4 and SE/4 of Section 7; Lots 1, 2, 3, & 4, E/2 NW/4, E/2 SW/4 & NE/4 of Section 18, all in T27S-R21W and SE/4 SE/4 of Section 12, T27S-R13W.

[6] Effective 8-1-86, Texaco Producing Inc. assigned to Raymond Oil Company Inc. its right, title, and interest in and to the NW/4 Sec. 32-T26S-R12W, Pratt County, Kansas.

[7] By assignment dated 12-13-86, effective 9-5-86, Texaco Inc. assigned to Huffco Petroleum Corporation its right, title, and interest in and to Eugene Island Block 275, OCS-G-0988, Offshore Louisiana.

[8] Applicant acquired by assignment an interest of Sun Exploration and Production Company, Assignor, in certain properties in Goliad County, Texas, effective 10-1-86.

[9] Applicant's contracts with Phillips terminate effective 6-1-87. Applicant intends to enter into a percentage-of-proceeds type arrangement to provide for processing of the gas at TPI's Eunice Plant. After processing, 60% of the residue gas would continue to be sold to El Paso by TPI at its Eunice, New Mexico Plant but under TPI's Gas Rate Schedule No. 390, Certificate No. CI72-771. Forty percent (40%) of the residue gas would be sold to Northern Natural Gas Company, Division of Enron Corp., by TPI at its Eunice, New Mexico Plant but under TPI's Gas Rate Schedule No. 389, Certificate No. CI72-762.

[10] On 8-27-86 (effective 4-1-86), Texaco Producing Inc. Assigned to Daniel Price Exploration Company all right, title and interest in the 6-18-85 contract with respect to gas produced from the reservoirs underlying the House "B" Gas Unit, Sec. 35-T8N-R21E, Haskell County, Oklahoma.

[11] Sun asssigned its interest in Property No. 845110, Jones CR 696, to TXO Production Corporation effective 6-1-86.

[12] Sun assigned Property No. 481207, Gegory C to Doyle Hartman.

[13] Sun assigned its interest in Property Nos. 461307, Fazekas Unit #1; 890442, Varnum Unit; 732082, USA Choctaw T-4, to Samson Resources Company effective 4-1-87.

[14] Sun assigned its interest in Property No. 720277, U.S. Government 27, to Samson Resources Company effective 4-1-87.

[15] Sun assigned its interest in Property No. 858110, McCutcheon -A- Unit, to TXO Production Corporation effective 6-1-86.

[16] Sun assigned its interest in Property No. 673475, Minnie B. Ross, to Sandollar Oil & Gas, Inc. effective 5-1-87.

[17] Sun assigned its interest in Property No. 703374, South Mineral Voss Unit, to Pioneer Oil and Gas effective 10-1-86.

[18] Sun assigned its interest in Property No. 668283, Riley Gas Unit #2; Property No. 638884, C. G. Newcomer Unit; Property No. 737922, Wainscott-McClure 2; Property No. 615690, McClure, Bert F-B, to TXO Production Corporation effective 6-1-86.

[19] Effective 10-1-86, Union Texas conveyed certain acreage to American Exploration Acquisition Co.

[20] To release gas for irrigation fuel.

[21] By assignment effective 1-1-87, ARCO assigned its interest in certain acreage to Hondo Oil and Gas Company.

[22] The subject well was a dual producer form the Morrow-Hoover zones. The Morrow became uneconomical to produce and consequently, was plugged and abandoned in June of 1984.

[23] Applicant is filing for a change in delivery point.

[24] Property sold to Union Exploration Partners, LTD, effective 2-1-87.

[25] Wells were plugged and abandoned in October of 1986.

[26] BHP Petroleum (Americas) Inc. has assigned to Public Energy, Inc. all of its right and title in certain acreage effective 9-10-86.

[27] BHP Petroleum (Americas) Inc. has assigned all of its right, title and interest effective 10-1-83 to Plains Resources Inc.

[28] Phillips is abandoning the sale of residue gas to El Paso attributable to gas purchased by Phillips from the Seminole Andres Unit operated by Amerada. Phillips and the Unit owners have entered into a buyout of the casinghead gas contracts which will reduce processing costs to the Unit owners. Disposition of the residue gas will continue to El Paso.

[29] Mobil Oil Corporation, an *et al.* party under Union's FERC Gas Rate Schedule No. 181, assigned its interest in a certain lease under Docket No. CI68-894 to Meadowbrook Oil Corporation of Oklahoma, Inc.

[30] Depleted and contract terminated.

[31] Depleted.

[32] Two leases have been released. Certain other leases were assigned to Duer Wagner & Co., Driscoll Production Co., and to Superior Oil Co. (now Mobil Producing Texas & New Mexico Inc.).

[33] Producing gas reservoir depleted, well was plugged on 10-17-73, and lease abandoned on the same date.

[34] Effective 1-1-86, Applicant conveyed the East Half of OCS-G-2531 to Tenneco Oil Company.

[35] The base term McCabe's contract with Farmland has expired and been canceled by McCabe due to the fact that the gas well is rapidly approaching its economic limits.

[36] The source of surplus residue gas dedicated to United under contract dated 1-31-67 and Rate Schedule No. 1 has been eliminated as of December, 1984.

[37] Uneconomical to continue sale under the present circumstances. Applicant wishes to seek another buyer.

[38] The Lucille W. McElroy Gas Unit, Wells Nos. 1UT, 1LT, 2UT, and 2LT have been plugged and abandoned. The gas reserves attributable to the wells have been depleted, and no further development is planned.

[39] Subject producing property has suffered decreased ability to flow against prevailing pipeline pressure. Applicant desires to connect well to low pressure pipeline system in area. Neither Applicant nor current gas purchaser find it economic to install compression facilities.

[40] The reserves are depleted.

[41] No gas has been purchased from the lease since about 1970 and the June 1, 1953, contract has expired. Applicant also requests a 3-year pregranted abandonment for spot market sales of the subject gas for resale in interstate commerce under Applicant's small producer certificate in Docket No. CS71-377.

[42] Applicant wishes to sell uncommitted 50% of reserves to another buyer. Such reserves were previously reserved for delivery under Applicant's warranty contract in FERC GRS #439. The certificated warranty volumes were delivered and the contract was canceled, effective 12-28-86. The remaining 50% interest remains dedicated to Sea Robin.

[43] Applicant wishes to sell uncommitted 50% of reserves to another buyer. Such reserves were previously reserved for delivery under Applicant's warranty contract in FERC GRS #439. The certificated warranty volumes were delivered and the contract was canceled, effective 12-28-86. The remaining 50% of reserves remains dedicated to Columbia.

[44] Purchaser no longer wants to purchase gas and has released it.

[45] Effective 2-1-86, Texaco Producing Inc. assigned to James A. Davidson all its rights, title and interest in and to the W/2 of Sec. 34-T25S-R37E, Lea County, New Mexico from the surface to a depth of 3700 feet.

[46] On 11-14-86 (effective 12-1-86), Texaco Producing Inc. assigned to Sid R. Bass Inc. *et al.*, interest in the M.J. Hill Lease.

[47] Applicant's application for abandonment was noticed on May 6, 1987 (52 Fed. Reg. 16896). The application is being renoticed herein to reflect Applicant's request for pregranted abandonment authority. Applicant states that no gas has been purchased from the lease since about 1970 and the December 31, 1957, contract has expired. Applicant also requests a 3-year pregranted abandonment for spot market sales of the subject gas for resale in interstate commerce under Applicant's small producer certificate in Docket No. CS71-377.

[48] Applicant will sell gas to Phillips 66 Natural Gas Company. The gas will continue to be delivered to El Paso at the tailgate of Phillips 66 NGC Lusk Plant.

[49] Additional material received May 19, 1987.

[50] Applicant requests a limited-term abandonment for one year of gas which is in excess of gas requested by Northern.

[51] This application was noticed on May 12, 1987. However that notice did not include Applicant's additional request received May 13, 1987, to grant pregranted abandonment authorization for three years for sales of gas under its small producer certificate.

[52] Applicant requests abandonment of gas sales to El Paso Natural Gas Company with three-year pregranted abandonment. El Paso has been unable to take gas since April 1986. Applicant's well produces NGPA section 106(a) gas and deliverability is 200 Mcf/d.

[53] This application was noticed on May 12, 1987. However that notice did not include Applicant's additional request received May 12, 1987, to grant pregranted abandonment authorization for three years for sales of gas under its small producer certificate.

[54] Applicant requests abandonment of gas sales to Mountain Fuel Resources with three-year pregranted abandonment for sales of gas under its small producer certificate. Mountain Fuel cancelled the contract effective February 15, 1987, and rescinded their rollover offer citing lack of markets and an intercompany decision not to add any reserves to their system.

[55] By assignment dated 4-26-84, effective 5-1-84 Applicant assigned its interest in the Wakita Trend Field, Grant County, Oklahoma, to Vernon E. Faulconer.

[56] Applicant is filing under Gas Purchase Contract dated 5-14-84 and Ratification Agreement dated 5-11-87.

[57] Economic infeasibility of maintaining its system prevented the purchase of gas from Crown Central Petroleum for resale to Northern. Crown canceled its contract with Horizon on July 1, 1985. Thus Horizon is filing to abandon the resale of Crown's gas to Northern.

[58] The wells are becoming uneconomic to produce due to a combination of a natural decline in oil and gas reserves and low prices. Because of the nature of the reservoir from which these wells produce, being a solution gas drive, the gas to oil ratio for the wells is steadily increasing as oil reserves are being depleted. As such, an increase in gas prices could operate to significantly extend the economic life of the wells, thus preventing premature abandonment and the loss of otherwise recoverable reserves. An authorized producer abandonment would allow Applicant to seek alternatives markets and more economic prices for this gas.

[59] Purchaser has terminated the sales contract.

[60] By Assignment dated 11-14-85, effective 6-1-85, Applicant acquired certain acreage from Sun Exploration and Production Company.

Filing Code: A—Initial Service; B—Abandonment; C—Amendment to add acreage; D—Amendment to delete acreage; E—Total Succession; F—Partial Succession.

[FR Doc. 87-13225 Filed 6-9-87; 8:45 am]
BILLING CODE 6717-01-M

[Docket No. GP87-48-000]

Preliminary Finding; Natural Gas Policy Act: Well Category Determination, Etc.

June 3, 1987

In the matter of Minerals Management Service, Louisiana, Section 102(d) NGPA Determination, Conoco, Inc., OCSD-0129 No. D-11 Well, MMS Docket No. G5-4802.

On February 25, 1987, the Minerals Management Service, Department of Interior (MMS) at New Orleans, Louisiana, submitted to the Commission a notice of determination. The notice stated that gas produced from the OCS-0129 No. D-11 well (D-11 well) in EA E-1 reservoir (EA sand) located on the outer Continental Shelf (OCS), offshore Louisiana, owned by Conoco, Inc. (Conoco) meets all the requirements of section 102(d) of the Natural Gas Policy Act of 1978 (NGPA).[1]

Under section 102(d)(1) of the NGPA, natural gas produced from an old lease on the OCS qualifies for the new natural gas ceiling price if the natural gas is produced from a reservoir which was not discovered before July 27, 1976. Section 102(d)(2) states that a reservoir that was penetrated by a well before July 27, 1986, will be considered to have been discovered before July 27, 1976, if any of the criteria in subsection 102(d)(B), concerning production tests and evidence regarding production capability, are satisfied. The section 102(d) criteria specifically refer to the requirements of OCS Order No. 4.[2]

On February 12, 1987, the MMS had submitted to the Commission a positive notice of determination for the OCS-0130 No. E-10 well completion in the same reservoir stating that the EA sand was a new reservoir because none of the wells which penetrated the reservoir prior to July 27, 1976, indicated that the reservoir was commercially producible.

In that case the record showed that prior to July 27, 1976 other wells had penetrated the EA sand and that one well, the Grand Isle 41 No. E-11 well, (E-11 well) had discovered the reservoir prior to July 21, 1976, within the meaning of section 102(d)(2)(B)(iii) of the NGPA because induction logs for that well indicated that the EA sand in that well showed in excess of 15 feet of producible sand. MMS stated it had issued a positive determination because a detailed economic analysis indicated that the E-11 well was not commercially producible as defined by Section 271.204 of the Commission's regulations.[3] However, on March 27, 1987, the Commission issued a preliminary finding on MMS' determination in Docket No. GP87-40-000.[4] The Commission stated that:

In this case there was evidence which appeared to satisfy the production capability test, within the meaning of NGPA section 102(d)(2)(B)(iii), since the induction-electric log test showed that the reservoir contained a zone of producible sand when the reservoir was penetrated prior to July 27, 1976. Under section 102(d)(4)(B), where evidence regarding production capability exists, the producer has the burden of showing the evidence does not provide the applicable indication specified in NGPA section 102(d)(2) that the reservoir was commercially producible. Here, Conoco has failed to do so.

Accordingly, the Commission hereby makes a preliminary finding under 18 CFR § 275.202(a)(1)(i) (1986), that the determination submitted by the MMS is not supported by substantial evidence in the record on which the determination was made, and issues this notice under 18 CFR 275.202(a)(2) (1986).[5]

On April 8, 1987, the Commission's staff requested MMS to explain the basis for the positive determination on the D-11 well in this case. On April 20, 1987,[6] MMS responded that its position was that NGPA section 102(d)(2) permits the consideration of economic evidence in determining whether the reservior is commercially producible. MMS noted that the same issue has been presented in Docket No. GP80-47-000 because that docket involved the same "disqualifying" well, namely, the E-11 well. MMS stated that the position it took in that docket was applicable to this docket as well.

The issue presented in this case is identical to the one in GP80-47-000. Accordingly, the Commission makes the same preliminary finding quoted *supra*, that the determination submitted by MMS is not supported by substantial evidence in the record on which the determination is made, and issues this notice under 18 CFR § 275.202(a)(2) (1986).

By direction of the Commission.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13169 Filed 6-9-87; 8:45 am]
BILLING CODE 6717-01-M

[Docket No. CI87-604-000]

Lewis B. Burleson; Application for Limited-Term Abandonment With Pregranted Abandonment for Sales Under Small Producer Certificate

June 3, 1987.

Take notice that on May 18, as supplemented on May 27, 1987, Lewis B. Burleson (Burleson) filed an application pursuant to section 7(b) of the Natural Gas Act and § 2.77 of the Commission's rules for a limited-term abandonment of

[1] 15 U.S.C. 3312(d) (1982).

[2] NGPA section 102(d)(5) defines OCS Order No. 4 as "the order numbered 4 of the Conservation Division, Geological Survey, Department of the Interior, as approved by the Chief of the Conservation Division on August 28, 1969." Order No. 4 sets forth certain tests, which if satisfied, permit an extension of an OCS lease beyond its primary term in the absence of actual production.

[3] 18 CFR 271.204 (1986).

[4] 38 FERC ¶ 61,316. The peliminary finding established a 120-day period, which ends on July 25, 1987, within which time the Commission may issue a final finding either reversing, remainding or approving the MMS determination, and permits parties to file comments to address the issues raised in the preliminary finding.

[5] *Id.* at 62,026-27.

[6] The request tolled the 45-day period for Commission action. That period did not commence until April 20, 1987, when the Commission received MMS' response.

his sale of gas to El Paso Natural Company (El Paso) from the State A-7 #1 Well, Section 7-T19S-R37E, and the Ascarte C-24 #1 and Ascarte D-24 #1 Wells Section 24-T25S-R36E, Lea County, New Mexico. Burleson requests a three-year limited-term abandonment with pregranted abandonment for sales of such gas under his small producer certificate in Docket No. CS69-36.

In support of his application Burleson states El Paso will not buy this gas as it has no market. Burleson proposes to sell the gas on the spot market under his small producer certificate. Burleson is subject to substantially reduced takes without payment. The subject wells are presently shut-in. The state A-7 #1 last produced in December 1984, the Ascarte C-24 #1 last produced in July 1984 and the Ascarte D-24 #1 last produced in June 1973. Burleson bought these wells from Conoco Inc. The wells are capable of producing a total of 96 Mcf/d. The gas is NGPA section 108 gas.

The circumstances presented in the application meet the criteria for consideration on an expedited basis, pursuant to § 2.77 of the Commission's rules as promulgated by Order Nos. 436 and 436-A, issued October 9, and December 12, 1985, respectively, in Docket No. RM85-1-000, all as more fully described in the application which is on file with the Commission and open to public inspection.

Accordingly, any person desiring to be heard or to make any protest with reference to said application should on or before 15 days after the date of publication of this notice in the **Federal Register**, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a petition to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR § 385.211, 385.214). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to the proceeding herein must file a petition to intervene in accordance with the Commission's rules.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Applicant to appear or to be represented at the hearing.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13224 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP85-8-006]

Canyon Creek Compression Co.; Change in FERC Gas Tariff

June 4, 1987.

Take notice that on May 29, 1987, Canyon Creek Compression Company (Canyon) tendered for filing Fourth Revised Sheet No. 4 to be a part of its FERC Gas Tariff Original Volume No. 1, to be effective July 1, 1987.

Canyon states that the tariff sheet was submitted in compliance with Article V of Canyon's Stipulation and Agreement at Docket No. RP85-8-000 (Agreement), which was approved by Commission's Order issued September 18, 1985. Article V of the Agreement provides that Canyon shall reflect in its rates any change in the corporate federal income tax rate. The Tax Reform Act of 1986 provides for a decrease in the corporate federal income tax rate from 46% to 34%. Accordingly, the revised rates reflect the effect of a 34% corporate federal income tax rate.

A copy of the filing was mailed to Canyon's jurisdictional customers, interested state regulatory agencies, and all parties set out on the official service list at Docket No. RP85-8-000.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with § 385.214 and 385.211. All such motions or protests must be filed on or before June 11, 1987. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13170 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP86-137-005]

Florida Gas Transmission Co.; Proposed Changes in FERC Gas Tariff

June 4, 1987.

Take notice that on May 29, 1987, Florida Gas Transmission Company (FGT), PO Box 1188, Houston, Texas 77251-1188 submitted for filing the following tariff sheets to its FERC Gas Tariff:

17th Revised Sheet No. 8 of First Revised Volume No. 1
40th Revised Sheet No. 128 of Original Volume No. 2
8th Revised Sheet No. 126 of Original Volume No. 3
7th Revised Sheet No. 181 of Original Volume No. 3
7th Revised Sheet No. 265 of Original Volume No. 3
7th Revised Sheet No. 283 of Original Volume No. 3
7th Revised Sheet No. 305 of Original Volume No. 3
7th Revised Sheet No. 365 of Original Volume No. 3
7th Revised Sheet No. 395 of Original Volume No. 3
7th Revised Sheet No. 423 of Original Volume No. 3
6th Revised Sheet No. 453 of Original Volume No. 3
4th Revised Sheet No. 486 of Original Volume No. 3
4th Revised Sheet No. 518 of Original Volume No. 3
4th Revised Sheet No. 549 of Original Volume No. 3
4th Revised Sheet No. 584 of Original Volume No. 3
3rd Revised Sheet No. 640 of Original Volume No. 3
4th Revised Sheet No. 658 of Original Volume No. 3

Reason for Filing

The above referenced tariff sheets are being filed in accordance with Article V of FGT's Stipulation and Agreement in Docket No. RP86-137-000 approved by the Federal Energy Regulatory Commission (FERC) on January 29, 1987. Pursuant to the provisions of Article V FGT agreed to file revised settlement base tariff rates to be effective July 1, 1987. The revised tariff sheets reflect the change in the statutory federal income tax rate from 46% to 34% as provided in the Tax Reform Act of 1986. The revised tariff sheets also reflect the effect of the amortization of the excess tax in the deferred income tax reserve resulting from the income tax rate change to 34%.

Copies of this filing were served on all of FGT's customers served under the rate schedules affected by this filing and the interested state commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE, Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's rules of practice and procedure. All such motions or protests should be filed on or before June 11, 1987. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies

of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13171 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP87-71-000]

Gas Research Institute; Annual Application

June 3, 1987.

Take notice that on June 1, 1987, Gas Research Institute (GRI), 8600 West Bryn Mawr Avenue, Chicago, Illinois 60631, filed herein an application requesting advance approval of its 1988-1992 Five-Year R&D Plan and 1988 R&D Program and the funding of its R&D activities for 1988 pursuant to the Natural Gas Act and the Commission's Regulations thereunder, particularly 18 CFR 154.38(d)(5).

GRI states that its application demonstrates compliance with the Commission's Regulations, the requirements of Opinion No. 252, Opinion and Order Amending and Approving Gas Research Institute's 1987 Research Development Program, Docket No. RP86-117-000, issued September 29, 1986, and the ongoing provisions of a Stipulation and Agreement reached by the parties to the proceedings in Docket No. RM77-14 and approved by the Commission in Opinion No. 11, Opinion and Order Approving the Initial Research Development and Demonstration Program of Gas Research Institute, Docket No. RM77-14, issued March 28, 1978. GRI's application seeks approval of its 1988 R&D Program and approval for its jurisdictional members to collect a R&D Funding Unit of 1.59 cents per Mcf or equivalent during the twelve months ending December 31, 1988, to support GRI's 1988 R&D program. This represents a 4.5 percent increase over the 1987 approved surcharge of 1.52 cents per Mcf.

GRI proposes a 1988 total obligations budget of $174.9 million which represents a decrease of about 6.3 percent from its approved 1987 obligations budget of $186.6 million. This proposes 1988 obligations budget of $174.9 million includes R&D obligations of $146.7 million; and project management and general expenses and capital asset purchases of $28.2 million. GRI proposes to fund 215 projects in 1988. GRI states about 98 percent of the R&D obligations budget would fund continuing projects. GRI proposes to fund $2.4 million in new activities.

GRI proposes a 1988 cash outlay budget of $160.1 million, a reduction of $14.8 million from the approved 1987 cash outlay budget of $174.9 million.

GRI states it is curtailing its 1988 obligations and outlay budget levels from approved 1987 levels in order to achieve an orderly transaction to a "steady state" budget profile targeted at the $175 million outlay level approved by the Commission in Opinion No. 252. GRI projects the required funding unit to increase to 1.67 cents (1988 dollars) in 1989 and to remain at 1.67 cents (1988 dollars) for the 1989-1992 period.

In Opinion No. 252, the Commission stated it would be appropriate with this filing to review GRI's past years of operation since with the 1988 Program, GRI will embark on its tenth year of operation. GRI states it has included in its application as Exhibit A, *Historical Review of GRI R&D,* a comprehensive report of GRI R&D to date that should greatly faciliate the Commission's review.

GRI's filing was accompanied by workpapers providing detail about its application. These workpapers are available for inspection in the Commission's Division of Public Information.

An appendix to the application contains a list of GRI members and state regulatory commissions which were served with a copy of GRI's application on June 1, 1987. Such members and commissions are hereby permitted to participate in this proceeding as intervenors and need not file formal motions to intervene or notices of intervention.

Any person desiring to be heard or to make any protest with reference to said application should on or before June 26, 1987, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a comment, protest, or motion to intervene in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.211 or 385.214). All comments or protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceedings. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein, other than those listed in the appendix to the application who are automatically entitled to participate, must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that a Commission staff report on GRI's filing will be served on all parties and filed with the Commission as a public document by July 31, 1987. Comments on the staff report by all parties except GRI should be filed with the Commission on or before August 14, 1987. GRI's reply comments should be filed on or before August 28, 1987. It should also be noted that the Commission's Regulations (18 CFR 381.206) provided that the fee for a petition seeking advance Commission approval of rate treatment of RD&D expenditures will be determined and billed according to the procedures for direct billing set forth under 18 CFR 318.107.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13227 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. EC87-11-000]

Kansas Gas and Electric Co.; Notice of Filing

June 4, 1987

Take notice that on March 13, 1987 Kansas Gas and Electric Company tendered for filing an application, pursuant to Section 203 of the Federal Power Act, for approval of a Sale Agreement respecting certain transmission facilities ("Sale Agreement") which provides for the sale of certain 69 kV transmission facilities located in southeasatern Kansas to the City of Chanute, Kansas.

Under the Sale Agreement, the City of Chanute obtains transmission facilities necessary to provide retail electric service to a newly annexed industrial customer.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, D.C. 20426, in accordance with Rules 214 or 211 of the Commission's rules of practice and procedure (18 CFR 385.211, 385.214). All such motions or protests should be filed on or before June 12, 1987. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13172 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CI87-621-000]

Mountain Industrial Gas Co.; Application

June 4, 1987.

Take notice that on May 22, 1987, Mountain Industrial Gas Company ("MIG") P.O. Box 1087, Colorado Springs, Colorado 80944 filed in Docket No. CI87-621-000 an "Application for Blanket Certificates of Public Convenience and Necessity and Order Permitting and Approving Abandonment and Pregranted Abandonment and Request for Temporary Authority" pursuant to sections 4 and 7 of the Natural Gas Act and Part 157 of the Federal Energy Regulatory Commission's ("Commission") Regulations.

MIG seeks a certificate of public convenience and necessity authorizing it to make: (i) Sales for resale in interstate commerce; (ii) sales of natural gas by others to MIG for resale in interstate commerce; (iii) sales for resale of natural gas in interstate commerce by producers through MIG acting on their behalf; and (iv) abandonment and pregranted abandonment of those sales described above, all as are more particularly described in its Application.

MIG also states that as an affiliate of an interstate pipeline, it is willing to accept those conditions placed on those other affiliates in the Commission's order in *Entrade Corporation, et al.* (March 31, 1987).

Any person desiring to be heard or to make any protest with reference to said application should on or before June 18, 1987, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a petition to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.211, .214). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken, but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party in any proceeding herein must file a petition to intervene in accordance with the Commission's rules.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Applicant to appear or to be represented at the hearing.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13228 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. RP85-150-008 and RP86-97-009]

Natural Gas Pipeline Company of America; Changes in FERC Gas Tariff

June 4, 1987

Take notice that on May 29, 1987, Natural Gas Pipeline Company of America (Natural) tendered for filing proposed changes in its FERC Gas Tariff, Third Revised Vol. No. 1, Original Volume No. 1A, and Second Revised Volume No. 2, to be effective July 1, 1987.

Natural states that the tariff sheets were submitted in compliance with Article V of Natural's Stipulation and Agreement at Docket No. RP85-150-000 (Agreement) and the Commission's Order issued May 8, 1987, at Docket Nos. RP86-97-000, *et al.* Article V of the Agreement provides that Natural shall reflect in its rates any change in the corporate federal income tax rate. The Tax Reform Act of 1986 provides for a decrease in the corporate federal income tax rate from 46% to 34% effective July 1, 1987. Accordingly, Natural filed revised rates to reflect the effect of the 34% corporate federal income tax rate. Pursuant to the Commission's Order issued May 8, 1987, at Docket Nos. RP86-97-000, *et al,* the filing also included revised base rates for Rate Schedule TRT-1.

A copy of the filing was mailed to Natural's jurisdictional customers, interested state regulatory agencies, and all parties set out on the official service list at Docket Nos. RP85-150-000 and RP86-97-000.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Captiol Street, NE., Washington, DC 20426, in accordance with §§ 385.214 and 385.211. All such motions or protests must be filed on or before June 11, 1987. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13173 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP85-69-005]

Penn-York Energy Corp.; Proposed Changes in FERC Gas Tariff

June 4, 1987

Take notice that on May 29, 1987, Penn-York Energy Corporation (Penn-York) tendered for filing proposed changes in its FERC Gas Tariff, Second Revised Volume No. 1. The proposed changes would decrease the storage service rate by 4.8¢ in accordance with Article VII, Federal Income Tax Tracker, of the "Stipulation of Agreement" in Docket No. RP85-69-002. This provision states that for each one percent change in Corporate Federal Income Tax Rate of 46 percent, Pen-York's rate under its rate schedule for storage service shall be decreased or increased by four-tenths of a cent. (.4¢) per Mcf. Penn-York states that the storage service rate decrease is in compliance with the "Stipulation of Agreement" in Docket No. RP85-69-002.

Penn-York states that copies of filing were served upon the company's jurisdictional customers and the regulatory commissions of the states of Connecticut, Delaware, Massachusetts, New Hampshire, New York, Pennsylvania, New Jersey and Rhode Island.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 214 and 211 of the Commission's rules of practice and procedure. All such motions or protests should be filed on or before June 11, 1987. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must flie a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13174 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP85-141-009]

Texas Gas Transmission Corp.; Proposed Changes in FERC Gas Tariff Sheets

June 4, 1987.

Take notice that on May 29, 1987 Texas Gas Transmission Corporation (Texas Gas) tendered for filing the following revised tariff sheets to its

FERC Gas Tariff, Original Volume No. 1 and FPC Gas Tariff, Original Volume No. 2:

FERC Gas Tariff, Original Volume No. 1

Seventh Revised Sheet No. 10
Seventh Revised Sheet No. 10A
Fourth Revised Sheet No. 11
Fourth Revised Sheet No. 12
Second Revised Sheet No. 12A
First Revised Sheet No. 13
First Revised Sheet No. 13A

FPC Gas Tariff, Original Volume No. 2

Sixth Revised Sheet No. 82
Twenty-second Revised Sheet No. 333
Seventh Revised Sheet No. 547
Seventh Revised Sheet No. 919
Ninth Revised Sheet No. 982
Seventh Revised Sheet No. 1005
First Revised Sheet Nos. 1123 through 1150

The revised tariff sheets are being filed to reflect a change in the base tariff rates due to a reduction in the non-gas cost of service from that approved in the "Order Approving Contested Offer of Settlement Subject to Modifications" issued Jaunuary 22, 1986, in Docket Nos. RP85-141-005 and RP85-141-002 (34 FERC Para. 61,054). This reduction is necessary to comply with Article V of the Stipulation and Agreement approved in the aforementioned order which states that Texas Gas will file to reflect any changes in the Federal Income Tax Rate approved by legislation. Pursuant to Article V, Texas Gas will reduce its cost of service $990,041 for each 1% change. Effective July 1, 1987, the Federal Income Tax Rate will be reduced from 46% to 34%. Concurrently, Texas Gas will reduce its cost of service by $11,880,492 which is reflected in the rates on the revised tariff sheets submitted herewith.

Copies of the filing were served on all parties in Docket No. RP85-141, as well as non-intervening customers and interested State Commission.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 2 11 and 2 14 of the Commission's rules of practice and procedure (18 CFR 385.211 and 385.214). All such motions or protests should be filed on or before June 11, 1987. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13175 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TA85-1-29-012]

Transcontinental Gas Pipe Line Corp.; Compliance Tariff Filing

June 4, 1987.

Take notice that Transcontinental Gas Pipe Line Corporation (Transco) on May 29, 1987 tendered for filing certain revised tariff sheets to its FERC Gas Tariff, Second Revised Volume No. 1. The proposed effective dates of the revised tariff sheets are April 1, 1987 and May 1, 1987.

Transco states the purpose of the tariff sheets proposed effective April 1, 1987 is to reflect, in compliance with Ordering Paragraph (G) of the Commission's Order issued May 18, 1987 in Docket Nos. TA85-1-29-011, *et al.*, revised rates for sales services which incorporate the appropriate base tariff rates which become effective April 1, 1987 in Docket No. RP87-7-007 adjusted to include the approximately $2.15 per dt cost of gas component reflected in Transco's PGA settlement approved and modified by the aforementioned Commission order of May 18, 1987. Furthermore, the revised tariff sheets proposed effective May 1, 1987 include the $2.15 per dt gas cost component and related surcharge adjustments which were approved by Commission order issued April 30, 1987 in Docket Nos. TA87-4-29-000, *et al.*

Transco further states that copies of the filing have been mailed to each of its customers and State Commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's rules of practice and procedure (18 CFR 385.211 and § 385.214). All such motions or protests should be filed on or before June 11, 1987. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13176 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP85-175-013]

Transwestern Pipeline Co.; Proposed Changes in FERC Gas Tariff

June 4, 1987

Take Notice that on May 29, 1987 Transwestern Pipeline Company (Transwestern) tendered for filing the following tariff sheets to its FERC Gas Tariff, Second Revised Volume No. 1, the following tariff sheets:

38th Revised Sheet No. 5
29th Revised Sheet No. 6

Reason for Filing

On January 16, 1986, Transwestern filed a Stipulation and Agreement (Agreement) resolving issues in the above-referenced proceeding and also in Docket No. CP86-276-000. As part of the Agreement, Transwestern filed a motion to place into effect on an interim basis the provisions of the Agreement, including the sales and transportation rates reflected therein. The motion was granted and the tariff sheets accompanying the motion were accepted by the Commission on February 14, 1986 to be effective February 1, 1986, subject to refund.

Article XI of the Agreement provided that Transwestern would increase or decrease its then effective rates appropriately to reflect the corresponding increase or decrease of the statutory federal income tax rate. On October 18, 1986, President Reagan signed into Law the Tax Reform Act of 1986 (the Act). Among other things, the Act reduced the statutory federal income tax rate related to corporations from 46% to 34%, effective July 1, 1987. The above-referenced tariff sheets are being filed herein by Transwestern pursuant to Article XI of the Agreement.

On January 28, 1987, the Commission issued its "Order Approving Contested Offer of Settlement as Modified and Clarified, Subject to Conditions" in Docket No. RP85-175-000. However, several parties filed motions for rehearing of the Commission's January 28, 1987 order. Although a final order has not been issued in this rate proceeding, Transwestern is tendering the above tariff sheets to continue to pass on to its jurisdictional customers the rate benefits of the pending settlement, including the rate reduction

due to the change in the statutory federal income tax rate as of July 1, 1987.

Transwestern proposes that the revised tariff sheets become effective on July 1, 1987, which date is not less than thirty (30) days after receipt of this filing by the Commission.

Copies of this filing were served on Transwestern's jurisdictional customers and interested State Commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE, Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's rules of practice and procedure. All such motions or protests should be filed on or before June 11, 1987. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13177 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. CI87-648-000]

Victoria Gas Corp.; Application for Blanket Sales Certificate With Pre-Granted Abandonment

June 4, 1987.

Take notice that on May 27, 1987, pursuant to Sections 4 and 7 of the Natural Gas Act (NGA), 15 U.S.C. 717-717z, and Part 157 and § 375.307(a)(9) of the regulations of the Federal Energy Regulatory Commission (Commission), 18 CFR Part 157, 375.307(a)(9), Victoria Gas Corporation (Victoria), a marketing company not affiliated with any interstate pipeline company, filed an application for a temporary and permanent blanket sales certificate. The certificate would enable Victoria to sell, with pre-granted abandonment, natural gas that remains subject to the Commission's NGA jurisdiction, and for which producers have received abandonment approval from the Commission through other procedures. The request blanket sales certificate and pre-granted abandonment authority would cover sales for resale of all jurisdictional Natural Gas Policy Act (NGPA) categories of gas in interstate commerce, including volumes whose maximum lawful price is at or below that established by section 109 of the NGPA.

Victoria seeks such authority for a one-year period, without prejudice to extension. Victoria's application requests that the Commission waive its regulations under 18 CFR Parts 154 and 271 concerning maintenance of rate schedules in order to permit Victoria to implement sales without the need for constant filings to conform to the conditions of each transaction. Victoria further requests any Commission declarations or waivers as may be necessary to ensure that the Commission's NGA jurisdiction over Victoria's activities and operations is limited to the transactions for which authorization is sought in this application.

Further, Victoria requests that pursuant to 18 CFR 157.28 and 375.307(a)(9), the Director of the Office of Pipeline and Producer Regulation issue Victoria a temporary certificate, pending expedited Commission review of its filing. Victoria states that because issuance of the certificate it requests is essential to permit Victoria to compete using the same marketing tools as its competitors, and because the purpose of this application is to market volumes of gas in instances where the producer has shut-in production or is subject to substantially reduced takes without payment, an emergency situation exists warranting issuance of a temporary certificate pending expedited Commission review the application.

Any person desiring to be heard or to make any protest with reference to Victoria's application should, on or before June 18, 1987, file with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission Rules of Practice and Procedure. All protests filed with the Commission will be considered by it in determining the appropriate actions to be taken but will not serve to make the protestants parties to the proceedings. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for the applicant to appear or to be represented at a hearing.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87-13226 Filed 6-9-87; 8:45 am]

BILLING CODE 6717-01-M

FEDERAL COMMUNICATIONS COMMISSION

Applications for Consolidated Hearing; Chartcom, Inc.

1. The Commission has before it the following mutually exclusive applications for a new FM station:

Applicant	City/State	File No.	MM Docket No.
A. Chartcom, Inc.	Salisbury, CT.	BPH-860122MN.	87-163
B. Victor Germack/Lori Shepard	Salisbury, CT.	BPH-860122MP.	
C. Alice Kaltman	Salisbury, CT.	BPH-860123NF.	
D. Family Stations, Inc.	Salisbury, CT.	BPH-860123NG.	
E. C. G. Associates of Salisbury	Salisbury, CT.	BPH-860123NH.	

2. Pursuant to section 309(e) of the Communications Act of 1934, as amended, the above applications have been designated for hearing in a consolidated proceeding upon the issues whose headings are set forth below. The text of each of these issues has been standardized and is set forth in its entirety under the corresponding headings at 51 FR 19347, May 29, 1986. The letter shown before each applicant's name, above, is used below to signify whether the issue in question applies to that particular applicant.

Issue Heading	Applicant(s)
1. Site availability	B
2. Ultimate	A,B,C,D,E
3. Comparative	A,B,C,D,E

3. If there is any non-standardized issue(s) in this proceeding, the full text of the issue and the applicant(s) to which it applies are set forth in an Appendix to this Notice. A copy of the

complete HDO in this proceeding is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text may also be purchased from the Commission's duplicating contractor, International Transcription Services, Inc., 2100 M Street NW., Washington, DC 20037. (Telephone (202) 857-3800).

W. Jan Gay,

Assistant Chief, Audio Services Division, Mass Media Bureau.

[FR Doc. 87-13240 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

Applications for Consolidated Hearing; RSO Broadcasting

1. The Commission has before it the following mutually exclusive applications for a new TV station:

Applicant	City/State	File No.	MM Docket No.
A. Richard S. Ohendalski d/b/a RSO Broadcasting	Fairmont, WV	BPCT-861117LA	87-167
B. John J. Garofalo d/b/a Skyway Television, Ltd	Fairmont, WV	BPCT-861208KG	
C. Carl M. Fisher	Fairmont, WV	BPCT-870212KG	

2. Pursuant to section 309(e) of the Communications Act of 1934, as amended, the above applications have been designated for hearing in a consolidated proceeding upon the issues whose headings are set forth below. The text of each of these issues has been standardized and is set forth in its entirety under the corresponding headings at 51 FR 19347, May 29, 1986. The letter shown before each applicant's name, above, is used below to signify whether the issue in question applies to that particular applicant.

Issue heading	Applicants
Short spacing	A, B
Air hazard	C
Comparative	A, B, C
Ultimate	A, B, C

3. If there is any non-standardized issue(s) in this proceeding, the full text of the issue and the applicant(s) to which it applies are set forth in an Appendix to this Notice. A copy of the complete HDO in this proceeding is available for inspection and copying during normal business hours in the FCC Docket Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text may also be purchased from the Commission's duplicating contractor, International Transcription Services, Inc. 2100 M Street, NW., Washington, DC 20037 (Telephone No. (202) 857-3800).

Roy J. Stewart,

Chief, Video Services Divsion, Mass Mdia Bureau.

[FR Doc. 87-13241 Filed 6-9-87; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Debarment From Eligibility for Financial Assistance

ACTION: Notice of Debarment.

SUMMARY: This notice announces the debarment of Robert E. McCaa, Ph.D from eligibility for direct or indirect financial assistance under any discretionary program awarded or administered by the Department of Health and Human Services.

EFFECTIVE DATE: The debarment became effective on July 15, 1986, and ends three years from the date.

FOR FURTHER INFORMATION CONTACT: Robert E. Lanman, Esq., Chief, National Institutes of Health Branch, Public Health Division, Office of the General Counsel, 9000 Rockville Pike, Building 31, Room 2B-50, Bethesda, Maryland 20892. Telephone: (301) 496-4108.

SUPPLEMENTARY INFORMATION: Pursuant to 45 CFR Part 76, Robert E. McCaa, Ph.D., 905 Briarwood Drive, Jackson, Mississippi 39211, has been debarred from receiving or applying for, directly or indirectly, any from of financial assistance under any discretionary program awarded or administered by the Department of Health and Human Services. The debarment applies to assistance provided through grants, cooperative agreements, felllowships, traineeships, loans, loan guarantee, and interest subsidies, as well as contracts, subcontracts, and subgrants supported by such assistance. It also debars Dr. McCaa from service or particpation in the conduct or performance of an assisted project. The debarment became effective on July 15, 1986. After three years from that date, Dr. McCaa may again apply to the Department of Health and Human Services for receipt of financial assistance.

This debarment action is based upon findings of an investigation conducted by the National Heart, Lung and Blood Institute (NHLBI) and the National Institutes of Health (NIH), that Dr. McCaa falsified and fabricated research data, published research papers that contained fabricated or misleading data, and submitted a grant application to the NHLBI which contained fabricated research data. Specifically, the NIH investigation established that Dr. McCaa intentionally published fabricated and false research data in the following research papers: "Role of Aldosterone in Experimental Hypertension," McCaa, McCaa, Bengis and Guyton, *Journal of Endocrinology,* 1979; "The Effects of Angiotensin I Concerting Enzyme Inhibitors on Arterial Blood Pressure and Urinary Sodium Excretion; Role of the Renal Renin Angiotensin and Kallikrein-Kinin System," *Circ. Res. 43: I32-I39,* 1978; Role of the Renal Renin Angiotensin System in Hypertension." McCaa, in *Proceedings of Symposium on Angiotensin Converting Enzyme Inhibitors Held in Puerto Rico* (1980); and "Regulation of Sodium Excretion Renal Function and Arterial Pressure," McCaa, in the *Role of Salt in Cardiovascular Hypertension,* Fregly and Kare, EDS (1982). In addition, it was found that Dr. McCaa knowingly submitted fabricated and fraudulent research data in a grant application to the NHLBI, No. 2-R01-HL-09921-17, in September 1981.

These findings were affirmed in the January 12, 1987 decision of the hearing officer designated under 45 CFR Part 76 and that officer determined, based upon evidentiary findings, that a three-year debarment, effective July 15, 1986, was appropriate. Pursuant to Dr. McCaa's request, the Secretary delegate, the Deputy Assistant Secretary for Procurement, Assistance and Logistics, reviewed and affirmed the decision of the hearing officer.

The findings in support of the debarment are set forth in detail in the decision of the hearing officer and the record of the hearing conducted by that officials. These findings clearly

demonstrate the existence of the causes for debarment under 45 CFR 76.10(d), (e) and (g).

Dated: June 4, 1987.

Henry G. Kirschenmann, Jr.,

Deputy Assistant Secretary for Procurement, Assistance and Logistics.

[FR Doc. 87-13223 Filed 6-9-87; 8:45 am]

BILLING CODE 4140-01-M

Food and Drug Administration

[Docket No. 87D-0186]

Automatic Detention and/or Examination of Imported Soft Cheese

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of Import Alert 12-03, "Automatic Detention and/or Examination of Imported Soft Cheese." This alert constitutes guidance to FDA staff for use in monitoring imported soft cheese. This guidance does not limit the agency's enforcement discretion to refuse or permit admission of a particular lot offered for import, after an evaluation of all relevant facts.

ADDRESS: Requests for single copies of Import Alert 12-03 and Chapter 9-73 of the Regulatory Procedures Manual should be sent to the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Brian Landesberg, Import Operations Branch (HFC-131), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-443-6553.

SUPPLEMENTARY INFORMATION: Import Alert 12-03, "Automatic Detention and/or Examination of Imported Soft Cheese," consists of two parts.

Part I of this import alert covers all imported soft cheese, except soft-ripened and goat cheese from France. Soft cheese from countries other than France, and from firms that are not under automatic detention, will be sampled and released according to guidelines in Regulatory Procedures Manual, Chapter 9-73, "Fresh Fish and Seafood and Perishable Produce."

Part II covers a revision of the French Plant and Product Certification Program, an informal certification program that the United States has entered into with France. Soft-ripened cheese plants that have been on the automatic detention list are being removed from that list when they qualify for the certification program.

Import Alert 12-03 is on file in the Dockets Management Branch (address above). Requests for single copies of the import alert and Chapter 9-73 of the Regulatory Procedures Manual should refer to the docket number found in brackets in the heading of this document and should be addressed to the Dockets Management Branch.

Dated: June 4, 1987.

John M. Taylor,

Associate Commissioner for Regulatory Affairs.

[FR Doc. 87-13165 Filed 6-9-87; 8:45 am]

BILLING CODE 4160-01-M

[Docket No. 87M-0174]

BGS Medical Corp.; Premarket Approval of Osteostim HS11

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing its approval of the application by BGS Medical Corp., Englewood, CO, for premarket approval, under the Medical Device Amendments of 1976, of the Osteostim HS11. After reviewing the recommendation of the Orthopedic and Rehabilitation Devices Panel, FDA's Center for Devices and Radiological Health (CDRH) notified the applicant of the approval of the application.

DATE: Petitions for administrative review by July 10, 1987.

ADDRESS: Written requests for copies of the summary of safety and effectiveness data and petitions for administrative review to the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Nirmal K. Mishra, Center for Devices and Radiological Health (HFZ-410), Food and Drug Administration, 8757 Georgia Ave., Silver Spring, MD 20910, 301-427-7156.

SUPPLEMENTARY INFORMATION: On July 30, 1986, BGS Medical Corp., Englewood, CO 80112, submitted to CDRH an application for premarket approval of the Osteostim HS11. The device is an implantable electrical bone growth stimulator. The device is indicated as a spinal fusion adjunct to increase the probability of fusion success. On February 19, 1987, the Orthopedic and Rehabilitation Devices Panel, an FDA advisory committee, reviewed and recommended approval of the application. On April 30, 1987, CDRH approved the application by a letter to the applicant from the Director of the Office of Device Evaluation, CDRH.

A summary of the safety and effectiveness data on which CDRH based its approval is on file in the Dockets Management Branch (address above) and is available from that office upon written request. Requests should be identified with the name of the device and the docket number found in brackets in the heading of this document.

A copy all approved labeling is available for public inspection at CDRH—contact Nirmal K. Mishra (HFZ-410), address above.

Oppportunity for Administrative Review

Section 515(d)(3) of the Federal Food, Drug, and Cosmetic Act (the act) 21 U.S.C. 360e(d)(3)) authorizes any interested person to petition, under section 515(g) of the act (21 U.S.C. 360e(g)), for administrative review of CDRH's decision to approve this application. A petitioner may request either a formal hearing under Part 12 (21 CFR Part 12) of FDA's administrative practices and procedures regulations or a review of the application and CDRH's action by an independent advisory committee of experts. A petition is to be in the form of a petition for reconsideration under § 10.33(b) (21 CFR 10.33(b)). A petitioner shall identify the form of review requested (hearing or independent advisory committee) and shall submit with the petition supporting data and information showing that there is a genuine and substantial issue of material fact for resolution through administrative review. After reviewing the petition, FDA will decide whether to grant or deny the petition and will publish a notice of its decision in the **Federal Register.** If FDA grants the petition, the notice will state the issue to be reviewed, the form of review to be used, the persons who may participate in the review, the time and place where the review will occur, and other details.

Petitioners may, at any time on or before July 10, 1987, file with the Dockets Management Branch (address above) two copies of each petition and supporting data and information, identified with the name of the device and the docket number found in brackets in the heading of this document. Received petitions may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

This notice is issued under the Federal Food, Drug, and Cosmetic Act (secs. 515(d), 520(h), 90 Stat. 554-555, 571 (21 U.S.C. 360e(d), 360j(h))) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10) and redelegated to the Director, Center for Devices and Radiological Health (21 CFR 5.53).

Dated: June 2, 1987.

James S. Benson,

Acting Director, Center for Devices and Radiological Health.

[FR Doc. 87-13166 Filed 6-9-87; 8:45 am]

BILLING CODE 4160-01-M

[Docket No. 87M-0165]

Bausch & Lomb Ophthalmic Instruments; Premarket Approval of Synemed Yagmaster ND: YAG Ophthalmic Laser

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing its approval of the application by Bausch & Lomb Ophthalmic Instruments, Rochester, NY, for premarket approval, under the Medical Device Amendments of 1976, of the Synemed YAGmaster Nd: YAG Ophthalmic Laser. After reviewing the recommendation of the Ophthalmic Devices Panel, FDA's Center for Devices and Radiological Health (CDRH) notified the applicant of the approval of the application.

DATE: Petitions for administrative review by July 10, 1987.

ADDRESS: Written requests for copies of the summary of safety and effectiveness data and petitions for administrative review to the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishes Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Philip J. Phillips, Center for Devices and Radiological Health (HFZ-460), Food and Drug Administration, 8757 Georgia Ave., Silver Spring, MD 20910, 301-427-8221.

SUPPLEMENTARY INFORMATION: On January 16, 1987, Bausch & Lomb Ophthalmic Instruments, Rochester, NY 14692, submitted to CDRH an application for premarket approval of the Synemed YAGmaster Nd:YAG Ophthalmic Laser. The Synemed YAGmaster Nd:YAG Ophthalmic Laser is a neodymium:yttrium-aluminum-garnet (Nd:YAG) ophthalmic laser that is indicated for discission of the posterior capsule of the eye (posterior capsultomy) and discission of pupillary membranes (pupillary membranectomy) in aphakic and pseudophakic eyes.

On February 26, 1987, the Ophthalmic Devices Panel, an FDA advisory committee, reviewed and recommended approval of the application. On April 30, 1987, CDRH approved the application by a letter to the applicant from the Director of the Office of Device Evaluation, CDRH.

A summary of the safety and effectiveness data on which CDRH based its approval is on file in the Dockets Management Branch (address above) and is available from that office upon written request. Requests should be identified with the name of the device and the docket number found in brackets in the heading of this document.

A copy of all approved labeling is available for public inspection at CDRH—contact Philip J. Phillips (HFZ-460), address above.

Opportunity for Administrative Review

Section 515(d)(3) of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 360e(d)(3)) authorizes any interested person to petition, under section 515(g) of the act (21 U.S.C. 360e(g)), for administrative review of CDRH's decision to approve this application. A petitioner may request either a formal hearing under Part 12 (21 CFR Part 12) of FDA's administrative practices and procedures regulations or a review of the application and CDRH's action by an independent advisory committee of experts. A petition is to be in the form of a petition for reconsideration under § 10.33(b) (21 CFR 10.33(b)). A petitioner shall identify the form of review requested (hearing or independent advisory committee) and shall submit with the petition supporting data and information showing that there is a genuine and substantial issue of material fact for resolution through administrative review. After reviewing the petition, FDA will decide whether to grant or deny the petition and will publish a notice of its decision in the **Federal Register.** If FDA grants the petition, the notice will state the issue to be reviewed, the form of review to be used, the persons who may participate in the review to be used, the persons who may participate in the review, the time and place where the review will occur, and other details.

Petitioners may, at any time on or before July 10, 1987, file with the Dockets Management Branch (address above) two copies of each petition and supporting data and information, identified with the name of the device and the docket number found in brackets in the heading of this document. Received petitions may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

This notice is issued under the Federal Food, Drug, and Cosmetic Act (secs. 515(d), 520(h), 90 Stat. 554-555, 571 (21 U.S.C. 360e(d), 360j(h))) and under the authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10) and redelegated to the Director, Center for Devices and Radiological Health (21 CFR 5.53).

Dated: June 3, 1987.

James S. Benson,

Acting Director, Center for Devices and Radiological Health.

[FR Doc. 87-13167 Filed 6-9-87; 8:45 am]

BILLING CODE 4160-01-M

[FDA 225-87-2002]

Memorandum of Understanding Between the National Fisheries Administration of the Republic of Korea and the Food and Drug Administration

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is providing notice of a memorandum of understanding (MOU) between the National Fisheries Administration (NFA), Republic of Korea, and FDA, U.S. Department of Health and Human Services. This MOU describes the sanitation practices, administrative controls, and responsibilities of FDA and NFA in implementing these practices and controls concerning the sanitary control of fresh frozen molluscan shellfish destined for exportation from Korea to the United States.

DATE: The agreement became effective April 8, 1987.

FOR FURTHER INFORMATION CONTACT: Walter J. Kustka, Intergovernmental and Industry Affairs Staff (HFC-50), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-443-1583.

SUPPLEMENTARY INFORMATION: In accordance with § 20.1089(c) (21 CFR 20.108(c)), which states that all agreements and memoranda of understanding between FDA and others shall be published in the **Federal Register,** the agency is publishing this memorandum of understanding.

Dated: June 4, 1987.

John M. Taylor,

Associate Commissioner for Regulatory Affairs.

Sanitary Control of Fresh Frozen Molluscan Shellfish Destined for Exportation From Korea to the United States

I. Purpose

The Food and Drug Administration (FDA) and the National Fisheries Administration (NFA) of the Ministry of Agriculture, Forestry and Fisheries of

the Republic of Korea (ROK) affirm by this memorandum their intention to continue the 1972 Shellfish Sanitation Agreement between the Government of the United States of America and the Government of the Republic of Korea. Both governments agree to cooperate in seeking to assure that fresh frozen molluscan shellfish exported from the Republic of Korea and offered for import into the United States are safe and wholesome and have been harvested, processed, transported, and labeled in accordance with the sanitation principles of the National Shellfish Sanitation Program (NSSP) and the requirements of the U.S. Federal Food, Drug and Cosmetic Act, the U.S. Public Health Service Act, the U.S. Fair Packaging and Labeling Act, and the Korean Ministry of Agriculture and Fisheries' Ordinance Number 699. This memorandum defines the sanitation practices and administrative controls and describes the responsibilities of FDA and NFA in implementing these practices and controls.

II. Background

Early in its history, the Republic of Korea established a national policy for fisheries development. This policy resulted in the rapid expansion of the oyster industry on the Korean south coast utilizing highly effective hanging culture methods. Given the possibility of exporting shellfish to markets in the United States (U.S.), the ROK promulgated laws and regulations to control the developing fisheries. Notable among these laws was Ministry of Agriculture and Fisheries Ordinance Number 699 which provides the basic legal authority for a Korean shellfish export program.

In 1967, the Korean Government requested technical consultation and advice on the development of an effective oyster production program from the US. Public Health Service and the U.S. Fish and Wildlife Service. The U.S. responded by sending a mission composed of public health and fisheries experts to Korea. The mission provided a detailed report with recommendations for developing a shellfish sanitation control program.

In 1970, the Director General of the Korean Office of Fisheries requested a second mission from the U.S. to evaluate the Korean Shellfish Sanitation Program (KSSP). The Food and Drug Administration sent a two person mission to Korea in September and October 1971. The mission concluded that the Korean program met or exceeded NSSP guidelines and, ". . . that the Korean Government can and will fulfill its responsibilities as a member of the National Shellfish Sanitation Program." On the basis of these conclusions, FDA endorsed the Korean Shellfish Sanitation Program.

On November 24, 1972, the Government of the United States of America signed two fishery agreements with the Government of the Republic of Korea. One concerned cooperation in fisheries in the North Pacific with special reference to the marketing of certain shellfish products. The other agreement applied to export of Korean fresh and frozen molluscan shellfish to the U.S. The signing of the latter agreement was contingent upon ratification of the fisheries agreement by the U.S. Because the 1971 FDA mission found that the Korean shellfish control program satisfied public health requirements, the U.S. ratified this agreement.

With the ratification of the 1972 Shellfish Sanitation Agreement, FDA officially recognized the ROK Office of Fisheries as the certifying authority for Korean shippers of fresh and fresh-frozen shellfish intended for U.S. markets. In accordance with this agreement, FDA had conducted annual reviews of the Korean Shellfish Sanitation Program and has found a high degree of compliance with NSSP guidelines. In 1980, the name of the ROK fisheries agency was changed from Office of Fisheries to National Fisheries Administration (NFA).

The sanitary control of shellfish in interstate commerce in the U.S. is administered by FDA in cooperation with state agencies under the NSSP. The NSSP provides the states and industry with a mechanism by which shellfish firms can be certified as shipping shellfish that have been harvested, handled, and processed in conformity with the sanitation and administrative guidelines of the NSSP. In most instances, food control authorities rely on the integrity of the NSSP certification controls to determine the acceptability of the shellfish product.

FDA and many foreign control authorities recognize that substantial benefit can result if shellfish that are to be offered for import in to the U.S. are harvested, handled, and processed in accordance with the procedures set forth in the NSSP. Therefore, it is FDA's policy to enter into memoranda of understanding with foreign control authorities that are willing to apply the sanitation and administrative controls of the NSSP to lots of shellfish that are intended to be exported and offered for import into the U.S. These agreements permit the foreign control authorities to certify firms and shippers of fresh frozen shellfish and to have these firms and shippers listed on FDA's "Interstate Certified Shellfish Shippers List" (ICSSL). FDA and American state authorities will recognize shipments so certified as having been certified under the NSSP.

Certification of foreign shellfish dealers exporting to the U.S. is normally limited to those dealers shipping fresh frozen products. This limitation is based on concerns over the possible introduction of exotic infectious organisms into U.S. fishery stocks from foreign fishery stocks. The processing and freezing of shellfish substantially reduce the possibility that such introductions will occur.

III. Substance of Agreement

A. Definitions

1. *Central file.* The "central file" is the location where the enforcement agency stores and maintains program information, data, and reports.

2. *Enforcement agency.* The "enforcement agency" is the National Fisheries Agency, which has regulatory authority in Korea over the production, harvesting, processing, transportation, classification, and export of certified shellfish to the United States under the terms of this memorandum.

3. *Lot.* A "lot" is a collection of primary containers or units of the same size, type, and style, produced under conditions as nearly uniform as possible, designated by a common container code or marking, and containing no more than a day's production.

4. *Marine biotoxins.* "Marine biotoxins" are natural toxins produced by dinoflagellates such as *Gonyaulax catenella, Gonyaulax tamarensis,* and *Ptychodiscus brevis* and concentrated by shellfish during the feeding process.

5. *Shellfish.* "Shellfish" are the edible species of oysters, clams, and mussels.

B. NFA Responsibilities

NFA will:

1. Maintain the legal, administrative, and sanitation controls over shellfish exported by Korean firms that are required by the NSSP and the KSSP. These controls include:

(a) Classifying shellfish harvesting areas based upon comprehensive sanitation surveys;

(b) Preparing sanitation survey reports and maintaining survey data in a central file;

(c) Updating survey data annually and periodically reviewing the classification status of each harvest area.

(d) Assuring that only shellfish harvested from approved areas that meet NSSP–KSSP approved water quality and marine biotoxin standards are exported to the U.S.;

(e) Evaluating laboratory practices used to test shellfish and seawater at least annually and encouraging participation in FDA's voluntary Quality Assurance Program. The Quality Assurance Program includes examination of standardized laboratory specimens supplied by FDA.

2. Inspect firms processing fresh frozen shellfish for export to the U.S. to ensure compliance with NSSP/KSSP controls.

3. Certify on an annual basis those firms that wish to process and to export fresh frozen shellfish to the U.S. that comply with NSSP/KSSP requirements and notify FDA of the name, location, and certification number of those firms on Form FD–3038B, "Shellfish Certification."

4. Cancel the certificate of any firm that does not comply with the requirements of NSSP/KSSP that obtains shellfish from nonapproved areas, or that ships shellfish that do not conform to appropriate program standards.

5. Ensure that all containers of each lot of fresh frozen shellfish certified for export are identified with the shipping firm's address, certification number, and lot number or code, together with all other information required by the U.S. Federal Food, Drug and Cosmetic Act, the U.S. Public Health Service Act, and U.S. Fair Packaging and Labeling Act.

6. Maintain a central file of program records including but not limited to sanitation survey reports, inspection reports, laboratory evaluation reports, and enforcement actions. NFA will make these records available to FDA upon request.

7. Reponsibilities for the management of various components of the KSSP may be delegated to subagencies or administrative units of NFA.

8. Provide FDA with an annual status report describing current or potential new public health problems affecting shellfish intended for export to the U.S. The report should present information on the level of conformity with NSSP requirements enforced by the NFA and a summary of the analysis of water and shellfish data to substantiate new designated area classifications.

9. Make travel arrangements in the Republic of Korea for, and conduct joint inspections with, FDA evaluation officers at FDA's request. Meet transportation expenses in the Republic of Korea of FDA officials making inspections in accordance with this memorandum.

C. FDA Responsibilities

FDA will:

1. Recognize the Republic of Korea as a participant in the NSSP with full rights to participate in national workshops, cooperative research programs, seminars, training courses, and other NSSP activities; to make recommendations for changes or improvements in the procedures, methods, standards, and guidelines of the NSSP; and to have NFA certify Korean firms for inclusion in FDA's ICSSL.

2. Publish the names, locations, and certification numbers of Korean shellfish shipping firms certified by NFA in the monthly publication of the ICSSL upon receipt of Form FD–3038B.

3. Provide limited training and technical assistance to enforcement agency personnel in shellfish sanitation program administration, laboratory procedures, and growing area classification procedures upon request of NEA and subject to availability of funds for such purposes.

4. Inform NFA of the reasons for any detentions of certified frozen shellfish shipments from Korea which have been carried out under the authority of the Federal Food, Drug and Cosmetic Act, as amended or Public Health Service (PHS) Act. Additional information that FDA will provide will include, but not necessarily be limited to:

(a) Commodity identification;

(b) Commodity code, lot, and certification numbers;

(c) Name and address of the shipper;

(d) Sampling procedures;

(e) Methods of analysis and confirmation; and

(f) Administrative guidelines.

5. Participate with NFA in joint evaluations of the shellfish sanitation program as it pertains to certifying firms. Joint evaluations normally will be conducted at two-year intervals to ascertain the level of conformity with the requirements of the NSSP and with the responsibilities specified in this memorandum. FDA will pay round trip transportation expenses between the United States and Korea and the per diem or the members of the FDA evaluation team while in Korea.

6. Facilitate the exchange of information between NFA and U.S. federal and state agencies concerned with the introduction and proliferation of exotic infectious organisms that might be carried by Korean shellfish.

D. Shared Responsibilities

NFA and FDA will:

1. Exchange information through nominated liaison officers concerning significant proposed and final changes in program operations and procedures including:

(a) Methods and procedures for sampling;

(b) Methods of analysis;

(c) Methods of confirmation;

(d) Administrative guidelines, tolerances, specification standards, and nomenclature;

(e) Reference standards; and

(f) Inspection procedures.

2. Provide written notification to the other party of any changes in liaison officers. Changing liaison officers will not otherwise constitute a change in the provisions of this memorandum.

E. Other Provisions

The working language for documents exchanged under this memorandum shall be English.

F. References

1. U.S. Department of Health and Human Services (formerly U.S. Department of Health, Education, and Welfare), PHS, National Shellfish Sanitation Program, Manual of Operations: Part I *Sanitation of Shellfish Growing Areas*, 1986 Revision; Part II *Sanitation of the Harvesting and Processing of Shellfish*, 1965 Revision.

2. Association of Official Analytical Chemists, Official Methods of Analysis, 14th Ed., Association of Official Analytical Chemists, Inc., 111 North 19th Street, Suite 210, Arlington, Va 22209, U.S.A., 1984.

3. Food and Drug Administration, "Interstate Certified Shellfish Shippers List," published monthly and distributed to food control officials and other interested persons by FDA, Center for Food Safety and Applied Nutrition, Shellfish Sanitation Branch (HFF–344), 200 C Street SW., Washington, D.C. 20204.

4. Federal Food, Drug, and Cosmetic Act, 1938, as amended, U.S. Code, Title 21.

5. Public Health Service Act, as amended, U.S. Code, Title 42.

6. Fair Packaging and Labeling Act, Public Law 89–755, approved November 3, 1966.

7. American Public Health Association, Recommended Procedures for the Examination of Seawater and Shellfish, 4th Ed., 1970, APHA, Inc., 1015 15 Street NW., Washington, D.C. 20036.

8. Food and Drug Administration "Current Good Manufacturing Practice in Manufacturing, Processing, Packing, or Holding Human Food," regulations, 21 CFR Part 110.

9. Food and Drug Administration, "Definitions and Standards for Food." "Fish and Shellfish" regulations, 21 CFR Part 161.

10. Food and Drug Administration, "Specific Administrative Decisions Regarding Interstate shipments," "Shellfish," 21 CFR 1240.60.

11. Food and Drug Administration, "Food Service Sanitation and Land and Air Conveyances, and Vessels," "Special Food Requirements," 21 CFR 1250.26.

12. 1972 Shellfish Sanitation Agreement between Government of the United States of America and the Government of the Republic of Korea.

IV. Part

A. National Fisheries Administration, 19th Floor Dae Wou Bldg., 5 Name Dae Mun Ro, Seoul, Korea.

B. Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, U.S.A.

V. Liaison Officers

A. Liaison Officer for NFA: Fishery Attache (currently Sang Chul Song), Embassy of the Republic of Korea, 2320 Massachusetts Avenue, Washington, DC 20008; Telephone: (202) 939–5675 ext. 75

B. Liaison Officer for FDA: Chief, Shellfish Sanitation Branch (currently David M. Dressel), Center for Food Safety and Applied Nutrition, Food and Drug Administration, 200 C Street SW., Washington, DC 20204. Telephone: (202) 485–0149

VI. Period of Agreement

This agreement will take effect when signed by representatives of both parties. It may be modified by mutual written consent or may be terminated by either party upon a 30-day advance written notice to the other party's liaison officer. Unless otherwise modified, this agreement will terminate 10 years after the effective date.

Appoved and Accepted for the National Fisheries Administration, Ministry of Agriculture, Forestry and Fisheries, Republic of Korea.

Dated: April 8, 1987.

Kang Yeung Sik,

Administrator.

Approved and Accepted for the Food and Drug Administration, Department of Health and Human Services, United States of America.

Dated: March 13, 1987.

John M. Taylor,

Associate Commissioner for Regulatory Affairs.

[FR Doc. 87–13168 Filed 6–9–87; 8:45 am]

BILLING CODE 4160–01–M

Public Health Service

National Toxicology Program; Availability of Technical Report on Toxicology and Carcinogenesis Studies of Ampicillin Trihydrate

The HHS' National Toxicology Program announces the availability of the toxicology and carcinogenesis studies of ampicillin trihydrate, a broad-spectrum semi-synthetic penicillin that is used in the treatment of upper respiratory tract infections, genital and urinary tract infections, and otitis media in children.

Toxicology and carcinogenesis studies of ampicillin trihydrate were conducted by administering the chemical in corn oil by gavage to groups of 50 F344/N rats and 50 B6C3F$_1$ mice of each sex, 5 days per week for 103 weeks. Male and female rats received doses of 0, 750, or 1,500 mg/kg, and male and female mice received doses of 0, 1,500 or 3,000 mg/kg.

Under the conditions of these 2-year gavage studies, there was equivocal evidence of carcinogenicity [1] of ampicillin trihydrate for male F344/N rats as shown by increased incidences of pheochromocytomas of the adrenal medulla and by marginally increased incidences of mononuclear cell leukemia. There was no evidence of carcinogenicity for female F344/N rats receiving 750 or 1,500 mg/kg or for male and female B6C3F$_1$ mice receiving 1,500 or 3,000 mg/kg per day. Nonneoplastic lesions of the forestomach were seen in male rats and male and female mice.

Copies of *Toxicology and Carcinogenesis Studies of Ampicillin Trihydrate in F344/N Rats and B6C3F$_1$* Mice (Gavage Studies) (TR 318) are available without charge from the NTP Public Information Office, MD B2–04, P.O. Box 12233, Research Triangle Park, NC 27709. Telephone: (919) 541–3991. FTS: 629–3991.

Dated: June 4, 1987.

David P. Rall,

Director.

[FR Doc. 87–13141 Filed 6–9–87; 8:45 am]

BILLING CODE 4140–01–M

National Toxicology Program; Availability of Technical Report on Toxicology and Carcinogenesis Studies of Pentachloronitrobenzene

The HHS' National Toxicology Program today announces the availability of the toxicology and carcinogenesis studies of pentachloronitrobenzene, a fungicide. Pentachloronitrobenzene is used as a soil fumigant for crops such as cotton, peanuts, barley, corn, oats, peas, wheat, and rice; vegetables such as beans, broccoli, lettuce, brussels sprouts, and potatoes; ornamental plants such as azaleas, roses, and carnations; and fruits such as bananas.

Toxicology and carcinogenesis studies of pentachloronitrobenzene were conducted by administering diets containing 0, 2,500 or 5,000 ppm pentachloronitrobenzene to groups of 50 B6C3F$_1$ mice of each sex for 103 weeks.

Under the conditions of these 2-year feed studies, there was no evidence of carcinogenicity [1] for either male or female B6C3F$_1$ mice receiving 2,500 or 5,000 ppm of pentachloronitrobenzene. Infection is considered to have decreased survival of the female mice and thus reduced the sensitivity for determining the presence or absence of a carcinogenic response.

Copies of *Toxicology and Carcinogenesis Studies of Pentachloronitrobenzene in B6C3F$_1$* Mice (Feed Studies) (TR 325) are available without charge from the NTP Public Information Office, MD B2–04, P.O. Box 12233, Research Triangle Park, NC 27709. Telephone (919) 541–3991. FTS: 629–3991.

Dated: June 4, 1987.

David P. Rall,

Director.

[FR Doc. 87–13142 Filed 6–9–87; 8:45 am]

BILLING CODE 4140–01–M

National Toxicology Program; Availability of Technical Report on Toxicology and Carcinogenesis Studies of Phenylephrine Hydrochloride

The HHS' National Toxicology Program today announces the availability of the Technical Report describing the toxicology and carcinogenesis studies of phenylephrine hydrochloride, a sympathomimetic agent used primarily as a nasal decongestant and as a mydriatic in ophthalmic applications.

Toxicology and carcinogenesis studies of USP-grade phenylephrine hydrochloride were conducted by administering diets containing the chemical to F344/N rats and B6C3F$_1$ mice of each sex at doses of 0, 620, and

[1] The NTP uses five categories of evidence of carcinogenicity to summarize the evidence observed in each animal study: two categories for positive results ("clear evidence" and "some evidence"), one category for uncertain findings ("equivocal evidence"), one category for no observable effect ("no evidence"), and one category for studies that cannot be evaluated because of major flaws ("inadequate study").

[1] The NTP uses five categories of evidence of carcinogenicity to summarize the evidence observed in each animal study: two categories for positive results ("clear evidence" and "some evidence"), one category for uncertain findings ("equivocal evidence"), one category for no observable effect ("no evidence"), and one category for studies that cannot be evaluated because of major flaws ("inadequate study").

1,250 ppm for rats and 0, 1,250 and 2,500 ppm for mice for 2 years. There were 50 animals in each group.

Under the conditions of these 2-year studies, there was no evidence of carcinogenicity[1] of phenylephrine hydrochloride for male or female F344/N rats given 620 or 1,250 ppm in feed or for male or female B6C3F$_1$ mice given 1,250 or 2,500 ppm in feed. Survival of high dose male rats was greater than that of controls, and the incidences of mononuclear cell leukemia and pheochromocytomas were lower in dosed than in control male rats. Inflammation was oberved more frequently in the liver and prostate gland of dosed male rats than in controls.

Copies of *Toxicology and Carcinogenesis Studies of Phenylephrine Hydrochloride in F344/N Rats and B6C3F$_1$* Mice (Feed Studies) (TR 322) are available without charge from the NTP Public Information Office, MD B2-04, P.O. Box 12233, Research Triangle Park, NC 27709. Telephone: (919) 541-3991. FTS: 629-3991.

Dated: June 6, 1987.

David P. Rall,

Director.

[FR Doc. 87-13143 Filed 6-9-87; 8:45 am]

BILLING CODE 4140-01-M

National Toxicology Program; Availability of Technical Report on Toxicology and Carcinogenesis Studies of 1,4-Dichlorobenzene

The HHS' National Toxicology Program today announces the availability of the Technical Report describing the toxicology and carcinogenesis studies of 1,4-dichlorobenzene, commonly used as a space deodorant in toilets and for moth control. Other applications include use as an intermediate in organic synthesis and as an animal repellant.

The toxicology and carcinogenesis studies were conducted by administering 1,4-dichlorobenzene in corn oil by gavage to male F344/N rats at doses of 0, 150, or 300 mg/kg and to female F344/N rats and male and female B6C3F$_1$ mice at doses of 0, 300, or 600 mg/kg per day for 2 years. There were 50 animals in each group.

Under the conditions of these 2-year gavage studies, 1,4-dichlorobenzene produced clear evidence of carcinogenicity [1] for male F344/N rats, as shown by an increased incidence of renal tubular cell adenocarcinomas. There was no evidence of carcinogenicity for female F344/N rats receiving doses of 300 or 600 mg/kg. There was clear evidence of carcinogenicity for both male and female B6C3F$_1$ mice, as shown by increased incidences of hepatocellular carcinomas and adenomas. Marginal increases were observed in the incidences of pheochromocytomas of the adrenal gland in male mice. Nonneoplastic effects in the kidney of male and female rats, in the liver of male and female mice, and in the thyroid gland and adrenal gland of male mice were also associated with the administration of 1,4-dichlorobenzene.

Copies of *Toxicology and Carcinogenesis Studies of 1,4-Dichlorobenzene in F344/N Rats and B6C3F$_1$* Mice (Gavage Studies) (TR 319) are available without charge from the NTP Public Information Office, MD B2-04, P.O. Box 12233, Research Triangle Park, NC 27709. Telephone: (919) 541-3991. FTS: 629-3991.

Dated: June 4, 1987.

David P. Rall,

Director.

[FR Doc. 87-13144 Filed 6-9-87; 8:45 am]

BILLING CODE 4140-01-M

National Toxicology Program; Availability of Technical Report on Toxicology and Carcinogenesis Studies of Tetrakis(Hydroxymethyl)Phosphonium Sulfate (THPS) and Tetrakis(Hydroxymethyl)Phosphonium Chloride (THPC)

The HHS' National Toxicology Program announces the availability of the toxicology and carcinogenesis studies of tetrakis(hydroxymethyl)phosphonium sulfate (THPS) and tetrakis(hydroxymethyl)phosphonium chloride (THPC), widely used as flame retardants in cotton fabrics.

Two-year studies were conducted in F344/N rats by administering 0, 5, or 10 mg/kg THPS or 0, 3.75, or 7.5 mg/kg THPC in deionized water by gavage to groups of 49 or 50 animals of each sex, 5 days per week for 103 or 104 weeks. Groups of 50 B6C3F$_1$ mice were administered 0, 5, or 10 mg/kg THPS (each sex), 0, 7.5, or 15 mg/kg THPC (males), or 0, 15, or 30 mg/kg THPC females.

Under the conditions of these 2-year gavage studies, there was no evidence of carcinogenicity [1] of THPS in either sex of F344/N rats or B6C3F$_1$ mice given 5 or 10 mg/kg. There was no evidence of carcinogenicity of THPC in either sex of F344/N rats given 3.75 or 7.5 mg/kg, in male B6C3F$_1$ mice given 7.5 or 15 mg/kg, or in female B6C3F$_1$ mice given 15 or 30 mg/kg.

Copies of *Toxicology and Carcinogenesis Studies of Tetrakis(Hydroxymethyl)Phosphonium Sulfate (THPS) and Tetrakis(Hydroxymethyl)Phosphonium Chloride (THPC) in F344/N Rats and B6C3F$_1$* Mice (Gavage Studies) (TR 296) are available without charge from the NTP Public Information Office, MD B2-04, P.O. Box 12233, Research Triangle Park, NC 27709. Telephone: (919) 541-3991. FTS: 629-3991.

Dated: June 4, 1987.

David P. Rall,

Director.

[FR Doc. 87-13145 Filed 6-9-87; 8:45 am]

BILLING CODE 4140-01-M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of Administration

[Docket No. N-87-1703]

Submission of Proposed Information Collections to OMB

AGENCY: Office of Administration, HUD.

ACTION: Notices.

SUMMARY: The proposed information collections requirements described below have been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposals.

ACTION: Interested persons are invited to submit comments regarding these proposals. Comments should refer to the

[1] The NTP uses five categories of evidence of carcinogenicity to summarize the strength of the evidence observed in each animal: two categories for positive results ("clear evidence" and "some evidence"), one category of uncertain findings ("equivocal evidence"), one category for no observable effect ("no evidence"), and one category for studies that cannot be evaluated because of major flaws ("inadequate studies").

[1] The NTP uses five categories of evidence of carcinogenicity to summarize the evidence observed in each animal study: two categories for positive results ("clear evidence" and "some evidence"), one category for uncertain findings ("equivocal evidence"), one category for no observable effect ("no evidence"), and one category for studies that cannot be evaluated because of major flaws ("inadequate study").

[1] The NTP uses five categories of evidence of carcinogenicity to summarize the evidence observed in each animal study: two categories for positive results ("clear evidence" and "some evidence"), one category for uncertain findings ("equivocal evidence"), one category for no observable effect ("no evidence"), and one category for studies that cannot be evaluated because of major flaws ("inadequate study").

proposal by name and should be sent to: John Allison, OMB Desk Office, Office of Management and Budget, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: David S. Cristy, Reports Management Officer, Department of HOusing and Urban Development, 451 7th Street, SW, Washington, DC 30410, telephone (202) 755–6050. This is not a toll-free number.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal described below for the collection of information to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35).

The Notice lists the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the information; (3) the description of the need for the information and its proposed use; (4) the agency form number, if applicable; (5) what members of the public will be affected by the proposal; (6) how frequently information submissions will be required; (7) an estimate of the total number of hours needed to prepare the information submission; (8) whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (9) the names and telephone numbers of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

Copies of the proposed forms and other available documents submitted to OMB may be obtained from David S. Cristy, Reports Management Officer for the Department. His address and telephone number are listed above. Comments regarding the proposal should be sent to the OMB Desk Officer at the address listed above.

The proposed information collection requirement is described as follows:

Submission of Proposed Information Collection to OMB

Proposal: Grant and Cooperative Agreement Request for Application and General Reporting Requirements for Grants and Cooperative Agreement Recipients
Office: Administration
Description of the Need for the Information and its Proposed Use: Potential recipients respond to a Request for Grant Application (RFGA) or Request for Cooperative Agreement application (RFCAA) in order to receive an award. All of this information is necessary in order for HUD program and grant officials to evaluate the application and make a decision on who receives an award.
Form Number: HUD–274
Respondents: Individuals or Households, State or Local Governments, Businesses or Other For-Profit, Non-Profit Institutions, and Small Businesses or Organizations
Frequency of Response: On Occasion, Quarterly, and Annually
Estimated Burden Hours: 32,005
Status: Extension
Contact: Glady G. Gines, HUD, (202) 755–5294, John F. Morrall, OMB, (202) 395–6880

Authority: Sec. 3507 of the Paperwork Reduction Act, 44 U.S.C. 3507; Sec. 7(d) of the Department of Hosuing and Urban Development Act 42 U.S.C. 3535(d).

Submission of Proposed Information Collection to OMB

Proposal: Study of Smoke Detector Removal in Manufactured Housing Fires
Office: Housing
Description of the Need for the Information and its Proposed Use: HUD is conducting a study of the impact of smoke detectors on fires in manufactured housing. The Department is concerned over the large number of manufactured home fire incidents where smoke detectors were reported as removed or not functioning in homes constructed to Federal standards.
Form Number: None
Respondents: State or Local Governments
Frequency of Response: Single-time
Estimated Burden Hours: 240
Status: New
Contact: Stuart I. Margulies, HUD, (202) 755–6584, John Allison, OMB, (202) 395–6880

Authority: Sec. 3507 of the Paperwork Reduction Act, 44 U.S.C. 3507; Sec. 7(d) of the Department of Housing and Urban Development Act, 42 U.S.C. 3535(d).

Submission of Proposed Information Collection to OMB

Proposal: Request for Refund of One Time Mortgage Insurance Premium (OTMIP)
Office: Administration
Description of the Need for the Information and its Proposed Use: The information will be used by the Department to identify the mortgage being refinanced, terminate the insurance, verify entitlement to a refund and compute the amount, support disbursement of public funds, and document payment instructions from the mortgagor. If the information is not received the Department can not expedite payment processing.
Form Number: HUD–27034
Respondents: Individuals or Households and Small Businesses Organizations
Frequency of Response: On Occasion
Estimated Burden Hours: 12,000
Status: Reinstatement
Contact: Robert E. Wiggins, HUD, (202) 755–8238, John Allison, OMB, (202) 395–6880

Authority: Sec. 3507 of the Paperwork Reduction Act, 44 U.S.C. 3507; Sec. 7(d) of the Department of Housing and Urban Development Act, 42 U.S.C. 3535(d).

Submission of Proposed Information Collection to OMB

Proposal: Section 202 Application Submission Requirements
Office: Housing
Description of the Need for the Information and its Proposed Use: This information is needed to assist HUD in determining applicant eligibility in developing housing for the elderly and handicapped. The information is used to evaluate an applicant's qualifications and capabilities so that the Government would be protected against possible fraud, waste, or mismanagement of public funds.
Form Number: HUD–92013
Respondents: Businesses or Other For-Profit
Frequency of Response: Annually
Estimated Burden Hours: 97,630
Status: Reinstatement
Contact: Aretha M. Williams, HUD, (202) 755–5866, John Allison, OMB, (202) 395–6880

Authority: Sec. 3507 of the Paperwork Reduction Act, 44 U.S.C. 3507; Sec. 7(d) of the Department of Housing and Urban Development Act, 42 U.S.C. 3535(d).

Dated: June 2, 1987.

John T. Murphy,

Director, Information Policy and Management Division.

[FR Doc. 87–13192 Filed 6–9–87; 8:45 am]

BILLING CODE 4210–01–M

DEPARTMENT OF THE INTERIOR

Office of the Secretary

[AA–650–06–4121–09]

Uinta-Southwestern Utah Regional Coal Team; Establishment

This notice is published in accordance with section 9(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463). Following consultation with the General Services Administration, notice is hereby given that the Secretary of the Interior (Secretary) is establishing a regional coal team (RCT) for the Uinta-

Southwestern Utah (Utah and Colorado) Federal coal production region. The RCT is an independent subcommittee of the Federal-State Coal Advisory Board renewed by the Secretary on October 3, 1986. As such, the RCT will guide all phases of coal activity planning in the region and will specifically provide advice to the Secretary, through the Director, Bureau of Land Management, on regional coal leasing levels and on Federal coal lease sale schedules and the tracts to be offered.

Further information regarding the committee may be obtained from the Director, Bureau of Land Management (650), U.S. Department of the Interior, 18th and C Streets, NW., Washington, DC 20240.

The certification of establishment is published below.

Certification

I hereby certify that the establishment of the Uinta-Southwestern Utah Regional Coal Team is necessary and in the public interest in connection with the performance of duties imposed on the Department of the Interior by those statutory authorities listed in 43 Code of Federal Regulations 3400.0–3 and by Departmental policy for Federal-State cooperation concerning the Federal coal management program.

Donald Paul Hodel,

Secretary of the Interior.

May 28, 1987.

[FR Doc. 87–13203 Filed 6–9–87; 8:45 am]

BILLING CODE 4310–84–M

Bureau of Land Management

[NV–060–4321–02]

Battle Mountain District Advisory Council Meeting in Tonopah, NV

SUMMARY: Notice is hereby given in accordance with Pub. L. 94–579 and 43 CFR Part 1780 that a meeting of the Battle Mountain District Advisory Council will be held on Tuesday, July 14, 1987. The meeting will convene at 9:00 a.m. in the Blue Room in the Tonopah Convention Center in Tonopah, Nevada.

SUPPLEMENTAL INFORMATION: The agenda for the meeting will include:

1. Surface Management.
   a. Continuation of general discussion.
   b. Drilling proposal in the Roberts Mountain WSA.
2. Update on wild horse program.
3. Stiener Creek Riparian Management Plan.

The meeting is open to the public. Interested persons may make oral statements between 1:00 and 1:30 p.m. on July 14, 1987. If you wish to make an oral statement, please contact Terry L. Plummer by 4:30 p.m. July 10, 1987.

FOR FURTHER INFORMATION CONTACT: Terry L. Plummer, District Manager, P.O. Box 1420, Battle Mountain Nevada 89820 or phone (702) 635–5181.

Dated: May 28, 1987.

Terry L. Plummer,

District Manager, Battle Mountain, Nevada.

[FR Doc. 87–13195 Filed 6–9–87; 8:45 am]

BILLING CODE 4310–HC–M

[NV–040–07–4321–12]

Hearing To Discuss the Use of Helicopters and Motorized Vehicles To Gather Wild Horses

AGENCY: Bureau of Land Management, Interior.

ACTION: Public hearing to discuss the use of helicopters and motorized vehicles to gather wild horses during FY 87.

SUMMARY: In accordance with Pub. L. 92–195, as amended by Pub. L. 94–579 and Pub. L. 95–514, this notice sets forth the public hearing date to discuss the use of helicopters and motorized vehicles to gather wild horses from the Ely District's Sand Springs Herd Management Area during FY 87.

The hearing will convene at 2:00 p.m. on Wednesday, July 15, 1987, in the Conference Room of the Ely District BLM Office, Pioche Highway, Ely, Nevada.

The hearing is open to the public. Interested persons may make oral or written statements. Anyone wishing to make oral comments should contact Robert E. Brown, Ely District Wild Horse Specialist, by July 10, 1987. Written statements must be received by this date also.

DATE: July 15, 1987.

ADDRESS: Bureau of Land Management, Star Route 5, Box 1, Ely, Nevada 89301.

FOR FURTHER INFORMATION CONTACT: Robert E. Brown, (702) 289–4865.

Dated: May 29, 1987.

Kenneth G. Walker,

District Manager.

[FR Doc. 87–13196 Filed 6–9–87; 8:45 am]

BILLING CODE 4310–HC–M

[AZ–020–07–4212–13; A–22764]

Public Land Exchange; Mohave County, AZ

AGENCY: Bureau of Land Management—Interior.

ACTION: Notice of realty action—exchange, public land, Mohave County, Arizona.

SUMMARY: The following described lands and interests therein have been determined to be suitable for disposal by exchange under section 206 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1716:

Gila and Salt River Meridian

T. 22 N., R. 19 W.,
Sec. 24, all;
Sec. 26, all;
Sec. 36, all.

Containing 1,920.00 acres, more or less.

In exchange for these lands, the United States will acquire the following described lands from James E. and Lois M. Briggs of Tucson, Arizona:

Gila and Salt River Meridian

T. 23 N., R. 19 W.,
Sec. 5, N½N½;
Sec. 7, N½NE¼W½;
Sec. 17, all.
T. 22 N., R. 20 W.,
Sec. 13, SE¼;
Sec. 25, all.
T. 23 N., R. 19 W.,
Sec. 29, all;
Sec. 31, all;
Sec. 33, all.

Containing 3,920.00 acres, more or less.

The public land to be transferred will be subject to the following terms and conditions:

1. Reservations to the United States: a). Right-of-way for ditches and canals pursuant to the Act of August 30, 1890; and b). all the oil and gas and with it the right to prospect for, mine, and remove same (except sec. 36).

2. Subject to: a). rights-of-way to the Mohave County Board of Supervisors for road purposes (A–19235, A–19236, A–19237, A–19238; sec. 36 only); b). right-of-way to Citizens Utilities Rural for buried telephone cable and road purposes (A–11509, A–19990); c). right-of-way to American Telephone and Telegraph Company for buried telephone cable purposes (AR–033346; sec. 36 only); d). reservation of all mineral to State of Arizona (sec. 36 only); and e). restrictions that may be imposed by the Mohave County Board of Supervisors in accordance with county floodplain regulations established under Resolution No. 84–10 adopted on December 3, 1984.

Private lands to be acquired by the United States will be subject to the following reservations:

1. All minerals to the Santa Fe Pacific Railroad Company together with the right to prospect for, mine, and remove same (except sec. 13, SE¼).

The purpose of the exchange is to consolidate federal land to facilitate

resource management in range, wildlife and recreation and to dispose of isolated, difficult to manage land with speculative development potential.

Publication of this Notice will segregate the subject lands from all appropriations under the public land laws, including the mining laws, but not mineral leasing laws. This segregation will terminate upon the issuance of a deed or patent or two years from the date of publication of this Notice in the **Federal Register** or upon publication of a Notice of Termination.

Detailed information concerning this exchange can be obtained from the Kingman Resource Area Office, 2475 Beverly Avenue, Kingman, Arizona 86401. For a period of forty-five (45) days from the date of publication of this Notice in the **Federal Register**, interested parties may submit comments to the District Manager, Phoenix District Office, 2015 West Deer Valley Road, Phoenix, Arizona 85027. Any adverse comments will be evaluated by the State Director who may sustain, vacate, or modify this realty action. In the absence of any objections, this realty action will become the final determination of the Department of the Interior.

Dated: June 1, 1987.

Henri R. Bisson,

District Manager.

[FR Doc. 87-13157 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-32-M

[NV-030-07-4212-14; N-42828]

Realty Action; Competitive Sale of Public Land in Douglas County, NV

The following described land, comprising approximately 296.875 acres, has been examined and identified as suitable for sale under section 203 of the Federal Land Policy and Management Act of October 21, 1976 (90 Stat. 2750), 43 U.S.C. 1713:

Mount Diablo Meridian, Nevada

T. 13 N., R. 21 E.,
Sec. 32: S½NE¼, S½N½NE¼, NW¼NW¼NE¼, W½NE¼NW¼NE¼, W½E½W½E½NE¼NW¼NE¼, W½W½E½NE¼NW¼NE¼, NE¼NW¼, N½SE¼, SE¼SE¼

The land will be offered at the appraised fair market value through a sealed bid only method of bidding. The date for submitting bids and the sale procedures, including the number of parcels and parcel sizes, and appraised value will be available to the public in a sale brochure.

The land is being offered for sale because it is not needed for any federal purpose and has more value in private ownership because of its potential for suburban or residential development. The sale is consistent with Bureau and local planning.

Patents, if and when issued, will contain the following reservations to the United States:

1. Rights-of-way thereon for ditches and canals constructed by the authority of the United States; Act of August 30, 1890, 26 Stat. 391; 43 U.S.C. 945.

The patents will also be subject to:

1. Easements, not exceeding 30 feet in width, for roadway and public utility purposes.

2. Easements for drainage controls in accordance with Douglas County planning.

3. Those rights for access road purposes granted to Douglas County, its successors and assigns, by Right-of-Way N-31504 under the authority of the Act of October 21, 1976.

The mineral estates will be conveyed simultaneously with the surface estates. A bid will constitute an application to purchase the mineral estate.

Detailed information concerning the sale is available for review at the Carson City District Office.

Upon publication of this notice in the **Federal Register**, the land described above will be segregated from all forms of nondiscretionary appropriation under the public land laws, including the mining laws. The segregative effect of this notice of realty action shall terminate upon issuance of patent or other document of conveyance to such land, upon publication in the **Federal Register** of a termination of the segregation or 270 days from the date of publication, whichever occurs first.

The land will be offered no earlier than 60 days after the date of this notice. For a period of 45 days after the date of this notice, interested parties may submit comments to the Bureau of Land Management, Carson City District Office, 1535 Hot Springs Road, Suite 300, Carson City, Nevada 89701. Any adverse comments will be evaluated by the District Manager. The Nevada State Director, Bureau of Land Management, may vacate or modify this realty action and issue a final determination. In the absence of any action by the State Director, this realty action will become the final determination of the Department of the Interior.

If the land is not sold at the first offering, sealed bids will be accepted at the Carson City District Office during business hours (7:30 am to 4:15 pm) every Wednesday following the date of the sale until the land is sold or withdrawn from sale.

Dated this 29th day of May 1987.

Norman L. Murray,

Acting, District Manager, Carson City District.

[FR Doc. 87-13155 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-HC-M

[NV-040-07-4212-11; N-44612]

Realty Action; Lease/Purchase for Recreation and Public Purposes, White Pine County, NV

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Realty Action. Recreation and Public Purpose Lease/Purchase, White Pine County.

SUMMARY: The following described public land, located approximately 1 mile south of the town of Baker in White Pine County, Nevada, has been identified and examined and will be classified as suitable for lease/purchase under the Recreation and Public Purpose Act, as amended (43. U.S.C. 869 et. seq.). The lands will not be offered for lease/purchase until at least 60 days after the date of publication of this notice in the **Federal Register**.

Mount Diablo Meridian, Nevada

T. 13 N., R. 70 E.,
Sec. 21, SE¼SE¼SE¼NE¼

This parcel of land contains approximately 2.5 acres.

White Pine County plans to establish a cemetery site for the community of Baker. The lease and/or patent, when issued, will be subject to the provisions of the Recreation and Public Purpose Act and applicable regulations of the Secretary of the Interior, and will contain the following reservations to the United States.

1. A right-of-way thereon for ditches and canals constructed by the authority of the United States, Act of August 30, 1890, 26 Stat. 391, 43 U.S.C. 945.

2. All minerals shall be reserved to the United States, together with the right to prospect for, mine, and remove such deposits from the same under applicable law and such regulations as the Secretary of the Interior may prescribe.

The lease/purchase will be subject to any prior and existing rights.

There will be no reduction of AUM's from the grazing allotment due to this action.

The land is not required for any federal purpose. The lease/purchase is consistent with the county and Bureau land use planning for this area.

Detailed information concerning this action is available for review at the

office of the Bureau of Land Management, Ely District, Ely, Nevada.

Upon publication of this notice in the **Federal Register**, the above described land will be segregated from all forms of appropriation under the public land laws, including the general mining laws, except for recreation and public purposes and leasing under the mineral leasing laws.

For a period of 45 days from the date of publication of this notice in the **Federal Register**, interested parties may submit comments to the District Manager, Ely District, Star Route 5, Box 1, Ely, Nevada 89301. Any adverse comments will be reviewed by the State Director. In the absence of comments, the classification of the land described in this notice will become effective 60 days from the date of publication in the **Federal Register**.

Dated: May 28, 1987.

Kenneth G. Walker,

District Manager.

[FR Doc. 87-13197 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-HC-M

[(OR-010-07-4212-21-GP7-199)]

Notice of Realty Action; Noncompetitive Permit or Lease of Public Land in Lake County, OR

The following described parcels of public land are being considered for permit or lease under section 302 of the Federal Land Policy and Management Act of 1976, (43 U.S.C. 1732), at not less than fair market value:

Parcel 1

T. 27 S., R. 19 E., W.M., Oregon
Section 20: NE¼NW¼.
Approximately 15 acres within.

Parcel 2

T. 27 S., R. 19 E., W.M., Oregon
Section 29: NE¼SE¼.
40 acres.

Parcel 3

T. 28 S., R. 16 E., W.M., Oregon
Section 18: NE1/4SW1/4.
Approximately 14 acres within.

The purpose of the permits or leases would be to authorize the existing agricultural use on parcels #1 and 3, and occupancy use on parcel #2. Since the private improvements presently exist on the subject parcels, the land will not be offered for permit or lease through competitive bidding. Parcels #1 and 3, currently under agricultural use, are irrigated by circular center pivot system and cultivated to alfalfa hay. The occupied parcel #2 presently contains a mobile home, small shed, a water holding tank and a series of animal pens, corrals and livestock feeding stanchions. The improvements were originally placed on public land in trespass when the original owners of the improvements mistakenly assumed the lands to be their own.

Parcels #1, 2, and 3 are being considered initially for authorization by permit to the ZX Land and Cattle Company of P.O. Box 7, Paisley, Oregon 97636. The permits would be issued for a term not to exceed three (3) years and would be renewable not to exceed an additional three (3) year term. The permits are intended to be utilized for interim authorization until a future determination concerning long-term lease or sale suitability can be made. The Bureau of Land Management will review the permit or lease proposals in accordance with the National Environmental Policy Act to access impacts and determine compatibility with land use plans for the area.

Information regarding these proposals can be reviewed in the Bureau of Land Management, High Desert Resource Area Office, 1000 South 9th Street, Lakeview, Oregon 97630, telephone (503) 947-2177.

For a period of forty-five (45) days from the date of publication interested parties may submit comments to the District Manager, Bureau of Land Management at the above address. Any adverse comments will be evaluated by the District Manager, who may vacate or modify this notice of realty action accordingly.

Dated: May 27, 1987.

Dick Harlow,

Associate District Manager.

[FR Doc. 87-13259 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-33-M

[CO-942-06-4520-12]

Colorado: Filing of Plats of Survey

June 1, 1987.

The plats of survey of the following described land will be officially filed in the Colorado State Office, Bureau of Land Management, Lakewood, Colorado, effective 10:00 A.M., June 1, 1987.

The supplemental plat showing the correct corner numbers of Mineral Survey No. 348, the correct position of Mineral Survey No. 1663, Bloated Bondholder Lode, an additional breakdown distance on the subdivisional line between sections 4 and 5, and creates lots 38 and 39 in section 5, T. 4 S., R. 74 W., Sixth Principal Meridian, Colorado was accepted May 21, 1987.

The plat representing the dependent resurvey of a portion of the subdivisional lines and certain claim lines, T. 6 N., R. 98 W., Sixth Principal Meridian, Colorado, Group No. 778, was accepted May 13, 1987.

The plat representing the dependent resurvey of portions of the south boundary and Mineral Survey No. 13355, Alkayo Tunnel No. 1 Lode; the corrective dependent resurvey of portions of the south boundary and subdivisional lines, and Mineral Survey No. 13355, Alkayo Tunnel No. 1 Lode, T. 14 S., R. 67 W., Sixth Principal Meridian, Colorado, Group No. 831, was accepted May 19, 1987.

These surveys were executed to meet certain administrative needs of this Bureau.

The plat representing the dependent resurvey of a portion of the subdivisional lines, T. 11 N., R. 77 W., Sixth Principal Meridian, Colorado, Group No. 816, was accepted May 15, 1987.

The plat representing the dependent resurvey of a portion of the subdivisional lines, T. 3 N., R. 76 W., Sixth Principal Meridian, Colorado, Group No. 823, was accepted May 15, 1987.

These surveys were executed to meet certain administrative needs of the U. S. Forest Service.

All inquiries about this land should be sent to the Colorado State Office, Bureau of Land Management, 2850 Youngfield Street, Lakewood, Colorado 80215.

Jack A. Eaves,

Chief Cadastral Surveyor for Colorado.

[FR Doc. 87-13156 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-JB-M

[OR-943-07-4520-10: GP7-205; 6-00151-GP7]

Filing of Plats of Survey: Oregon/Washington

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The plats of survey of the following described lands have been officially filed in the Oregon State Office, Portland, Oregon on the dates hereinafter stated:

Willamette Meridian

Oregon

T. 37 S., R. 3 W.
T. 37 S., R. 4 W.

The above-listed plats were accepted February 13, 1987 and officially filed February 25, 1987.

T. 21 S., R. 6 W.
T. 22 S., R. 10 E.

The above-listed plats were accepted February 20, 1987 and officially filed February 25, 1987.

T. 16 S., R. 7 W., accepted March 20, 1987 and offically filed April 8, 1987.

T. 40 S., R. 12 E.
T. 40 S., R. 13 E.

The above-listed plats were accepted March 13, 1987 and officially filed April 13, 1987.

T. 29 S., R. 12 W.
T. 30 S., R. 12 W.

The above-listed plats were accepted April 10, 1987 and officially filed April 13, 1987.

Washington

T. 30 N., R. 7 W.
T. 37 N., R. 34 E.

The above-listed plats were accepted February 27, 1987 and officially filed March 10, 1987.

T. 26 N., R. 2 E., accepted March 20, 1987 and officially filed April 8, 1987.

The above listed plats represent dependent resurvey, metes and bounds survey, completion survey and subdivisions.

FOR FURTHER INFORMATION CONTACT: Bureau of Land Management, 825 N.E. Multnomah Street, P.O. Box 2965, Portland, OR 97208.

B. LaVelle Black,

Chief, Branch of Lands and Minerals Operations.

[FR Doc. 87-13158 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-33-M

Minerals Management Service

Information Collection Submitted for Review

The proposal for the collection of information listed below has been submitted to the Office of Management and Budget for approval under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35). Copies of the proposed information collection requirement and related forms and explanatory material may be obtained by contacting Jeane Kalas at 303-231-3046. Comments and suggestions on the requirement should be made directly to the Bureau Clearance Officer at the telephone number listed below and to the Office of Management and Budget Interior Department Desk Officer, Washington, DC 20503, telephone 202-395-7340.

Title: Production Accounting and Auditing System Reports on Solid Minerals.

Abstract: Production Accounting and Auditing System (PAAS) information is needed to provide comprehensive production and disposition data on solid minerals produced from Federal and Indian leases. The data collected from lease and mine operators will be used to monitor production and check reported disposition against royalties. Data will also be used for audits. The monitoring function will enable MMS to verify that proper royalties are being received for minerals produced from Federal and Indian land.

Bureau Form Numbers: MMS-4050, MMS-4059A and B, MMS-4060A and B.

Frequency: Intermittently, monthly, quarterly.

Description of Respondents: companies producing and processing solid minerals from Federal and Indian leases.

Annual Responses: 2,220.

Annual Burden Hours: 2,240.

Bureau Clearance Officer: Dorothy Christopher, 703-435-6213.

Dated: April 27, 1987.

Donald A. Panella,

Associate Director for Royalty Management.

[FR Doc. 87-13260 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-MR-M

Outer Continental Shelf Development Operations Coordination Document; ODECO Oil & Gas Co.

AGENCY: Minerals Management Service.

ACTION: Notice of the receipt of a proposed development operations coordination document (DOCD).

SUMMARY: Notice is hereby given that ODECO Oil & Gas Company has submitted a DOCD describing the activities it proposes to conduct on Lease OCS 044, Block 89, Lease OCS 0228, Block 93 (portion), Lease OCS 0229, Block 90 (portion), Eugene Island Area, offshore Louisiana. Proposed plans for the above area provide for the development and production of hydrocarbons with support activities to be conducted from onshore bases located at Dulac and Houma, Louisiana.

DATE: The subject DOCD was deemed submitted on June 2, 1987.

ADDRESS: A copy of the subject DOCD is available for public review at the Public Information Office, Gulf of Mexico OCS Region, Minerals Management Service, 1201 Elmwood Park Boulevard, Room 114, New Orleans, Louisiana (Office Hours: 8 a.m. to 4:30 p.m., Monday through Friday).

FOR FURTHER INFORMATION CONTACT: Michael J. Tolbert; Minerals Management Service, Gulf of Mexico OCS Region, Field Operations, Plans, Platform and Pipeline Section, Exploration/Development Plans Unit; Telephone (504) 736-2867.

SUPPLEMENTARY INFORMATION: The purpose of this Notice is to inform the public, pursuant to sec. 25 of the OCS Lands Act Amendments of 1978, that the Minerals Management Service is considering approval of the DOCD and that it is available for public review.

Revised rules governing practices and procedures under which the Minerals Management Service makes information contained in DOCDs available to affected States, executives of affected local governments, and other interested parties became effective December 13, 1979 (44 FR 53685). Those practices and procedures are set out in revised § 250.34 of Title 30 of the CFR.

Dated: June 3, 1987.

J. Rogers Pearcy,

Regional Director, Gulf of Mexico OCS Region.

[FR Doc. 87-13153 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-MR-M

Outer Continental Shelf Development Operations Coordination Document; Union Exploration Partners, Ltd.

AGENCY: Minerals Management Service.

ACTION: Notice of the Receipt of a Proposed Development Operations Coordination Document (DOCD).

SUMMARY: Notice is hereby given that Union Exploration Partners, Ltd. has submitted a DOCD describing the activities it proposes to conduct on Leases OCS 0205 and 0341, Blocks 38 (portion) and 39 (portion), respectively, Vermilion Area, offshore Louisiana. Proposed plans for the above area provide for the development and production of hydrocarbons with support activities to be conducted from an onshore base located at Intracoastal City, Louisiana.

DATE: The subject DOCD was deemed submitted on June 2, 1987.

ADDRESS: A copy of the subject DOCD is available for public review at the Public Information Office, Gulf of Mexico OCS Region, Minerals Management Service, 1201 Elmwood Park Boulevard, Room 114, New Orleans, Louisiana (Office Hours: 8 a.m. to 4:30 p.m., Monday through Friday).

FOR FURTHER INFORMATION CONTACT: Michael J. Tolbert; Minerals Management Service, Gulf of Mexico OCS Region, Field Operations, Plans, Platform and Pipeline Section, Exploration/Development Plans Unit; Telephone (504) 736.2867..

SUPPLEMENTARY INFORMATION: The purpose of this Notice is to inform the

public, pursuant to sec. 25 of the OCS Lands Act Amendments of 1978, that the Minerals Management Service is considering approval of the DOCD and that it is available for public review.

Revised rules governing practices and procedures under which the Minerals Management Service makes information contained in DOCDs available to affected States, executives of affected local governments, and other interested parties became effective December 13, 1979 (44 FR 53685). Those practices and procedures are set out in revised § 250.34 of Title 30 of the CFR.

Dated: June 3, 1987.

J. Rogers Pearcy,

Regional Director, Gulf of Mexico OCS Region.

[FR Doc. 87-13154 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-MR-M

National Park Service

Intention to Negotiate Concession Contract

Pursuant to the provisions of section 5 of the Act of October 9, 1965 (79 Stat. 969; 16 U.S.C. 20), public notice is hereby given that sixty (60) days after the date of publication of this notice, the Department of the Interior, through the Director of the National Park Service, proposes to negotiate a concession contract with Cape Hatteras Fishing Pier, Inc., authorizing it to continue to provide a fishing pier and pier house and related facilities and services for the public within Cape Hatteras National Seashore for a period of five (5) years from January 1, 1988, through December 31, 1992.

This contract renewal has been determined to be categorically excluded from the procedural provisions of the National Environmental Policy Act and no environmental document will be prepared.

The foregoing concessioner has performed its obligations to the satisfaction of the Secretary under an exising contract which expires by limitation of time on December 31, 1987, and therefore, pursuant to the Act of October 9, 1965, as cited above, is entitled to be given preference in the renewal of the contract and in the negotiation of a new contract as defined in 36 CFR 51.5.

The Secretary will consider and evaluate all proposals received as a result of this notice. Any proposal, including that of the existing concessioner, must be postmarked or hand-delivered on or before the sixtieth (60th) day following publication of this notice to be considered and evaluated. Interested parties should contact the Regional Director, Southeast Region, 75 Spring Street, SW., Atlanta Georgia, 30303, for information as to the requirements of the proposed contract.

C.W. Ogle,

Acting Regional Director, Southeast Region.

[FR Doc. 87-13164 Filed 6-9-87; 8:45 am]

BILLING CODE 4310-70-M

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337-TA-251]

Certain Electronic Chromatogram Analyzers, Commission Decision to Review Portions of Initial Determination; Schedule for Filing Written Submissions on Remedy, the Public Interest, and Bonding

AGENCY: International Trade Commission.

ACTION: The U.S. International Trade Commission has determined to review portions of an initial determination (ID) finding no violation of section 337 in the above-captioned investigation. The portions of the ID that will be reviewed are the presiding administrative law judge's (ALJ's) determination regarding patent validity under 35 U.S.C. 103 (obviousness), infringement, and the existence of a domestic industry. The parties to the investigation and interested government agencies are requested to file written submissions on the issues of remedy, the public interest, and bonding. No submissions concerning the issues under review will be accepted. Comments from other interested persons will be accepted on the issues of remedy, the public interest, and bonding.

FOR FURTHER INFORMATION CONTACT: Jean H. Jackson, Esq., Office of the General Counsel, U.S. International Trade Commission, 701 E Street, NW., Washington, DC 20436, telephone 202-523-1693.

SUMMARY: On April 9, 1987, the ALJ issued an ID finding that there is no violations of section 337 of the Tariff Act of 1930 (19 U.S.C. 1337) in the importation and sale of certain electronic chromatogram analyzers. Complaint and the Commission investigative attorneys (IAs) filed petitions for review of the ID, and respondents, complainant, and the IAs filed responses. No agency comments were received.

Having examined the record in this investigation, including the ID of the ALJ, the petitions for review and the responses thereto, the Commission has determined to review portions of the ID. Specifically, the Commission has decided that the following issues warrant review:

1. Whether the claims at issue of U.S. Letters Patent 4,019,057 are invalid as obvious under 35 U.S.C. 103;

2. Whether the claims at issue of U.S. Letters Patent 4,019,057 are infringed by respondents' chromatogram analyzers;

3. Whether complainant's chromatogram analyzers are made in accordance with the patent issue (i.e., whether a domestic industry exists).

No other issues will be reviewed.

SUPPLEMENTARY INFORMATION: If the Commission finds that a violation of section 337 has occurred, it may issue (1) an order which could result in the exclusion of the subject articles from entry into the United States and/or (2) cease and desist orders which could result in respondents being required to cease and desist from engaging in unfair acts in the importation and sale of such articles. Accordingly, the Commission is interested in receiving written submissions which address the form of relief, if any, which should be ordered.

If the Commission concludes that a violation of section 337 has occurred and contemplates some form of relief, it must consider the effect of that relief upon the public health and welfare, competitive conditions in the U.S. economy, the U.S. productions of articles which are like or directly competitive with those that are subject to investigation, and U.S. consumers. The Commission is therefore interested in receiving written submissions concerning the effect, if any, that granting relief would have on the public interest.

If the Commission finds that a violation of section 337 has occurred and orders some form of relief, the President has 60 days to approve or disapprove the Commission's action. During this period, the subject articles would be entitled to enter the United States under a bond in an amount determined by the Commission and prescribed by the Secretary of the Treasury. The Commission is therefore interested in receiving written submissions concerning the amount of the bond which should be imposed.

Written Submissions: The parties to the investigation and interested government agencies are requested to file written submissions on the issues of remedy, the public interest, and bonding. Complainant and the Commission investigative attorneys are also requested to submit a proposed

remedial order(s) for the Commission's consideration. Written submissions on the issues of remedy, the public interest, and bonding must be filed no later than the close of business on June 9, 1987. Reply submission must be filed no later than the close of business on June 16, 1987. Persons other than the parties and government agencies may file written submissions addressing the issue of remedy, the public interest, and bonding. Such submissions must be filed not later than the close of business on June 16, 1987. No further submissions will be permitted.

Commission Hearing: The Commission does not plan to hold a public hearing in connection with final disposition of this investigation.

Additional Information: Persons submitting written submissions must file the original document and 14 true copies thereof with the Office of the Secretary on or before the deadlines stated below. Any person desiring to submit a document (or a portion thereof) to the Commission in confidence must request confidential treatment unless the information has already been granted such treatment by the ALJ. All such requests should be directed to the Secretary to the Commission and must include a statement of the reasons why the Commission should grant such treatment. Documents containing confidential information approved by the Commission for confidential treatment will be treated accordingly. All nonconfidential written submissions will be available for public inspection at the Secretary's Office.

This actions is taken under the authority of section 337 of the Tariff Act of 1930 (19 U.S.C. 1337) and Commission rule § 210.54 (19 CFR 210.54).

Notice of this investigation was published in the **Federal Register** of July 9, 1986 (51 FR 24945–46).

Copies of the nonconfidential version of the ID and all other nonconfidential documents filed in connection with this investigation are available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 701 E Street, NW., Washington, DC 20436, telephone 202–523–0161. Hearing impaired individuals are advised that information on this matter can be obtained by contacting the Commission TDD terminal on 202–724–0002.

By order of the Commission.

Issued: June 3, 1987

Kenneth R. Mason,

Secretary.

[FR Doc. 87–13187 Filed 6–9–87; 8:45 am]

BILLING CODE 7020–02–M

[Investigation No. 731–TA–371 (Final)]

Fabric and Expanded Neoprene Laminate From Taiwan

AGENCY: United States International Trade Commission.

ACTION: Institution of a final antidumping investigation and scheduling of a hearing to be held in connection with the investigation.

SUMMARY: The Commission hereby gives notice of the institution of final antidumping investigation No. 731–TA–371 (Final) under section 735(b) of the Tariff Act of 1930 (19 U.S.C. 1673d(b)) to determine whether an industry in the United States is materially injured, or is threatened with material injury, or the establishment of an industry in the United States is materially retarded, by reason of imports from Taiwan of fabric and expanded neoprene laminate, provided for in items 355.81, 355.82, 359.50, and 359.60 of the Tariff Schedules of the United States, that have been found by the Department of Commerce, in a preliminary determination, to be sold in the United States at less than fair value (LTFV). Unless the investigation is extended, Commerce will make its final LTFV determination on or before July 22, 1987, and the Commission will make its final injury determination by September 10, 1987 (see sections 735(a) and 735(b) of the act (19 U.S.C. 1673d(a) and 1673d(b))).

For further information concerning the conduct of this investigation, hearing procedures, and rules of general application, consult the Commission's Rules of Practice and Procedure, part 207, subparts A and C (19 CFR Part 207), and part 201, subparts A through E (19 CFR Part 201).

EFFECTIVE DATE: May 14, 1987.

FOR FURTHER INFORMATION CONTACT: Bruce Cates (202–523–0369), Office of Investigations, U.S. International Trade Commission, 701 E Street N W., Washington, DC 20436. Hearing-impaired individuals may obtain information on this matter by contacting the Commission's TDD terminal on 202–724–0002. Information may also be obtained via electronic mail by calling the Office of Investigations' remote bulletin board system for personal computers at 202–523–0103. Persons with mobility impairmants who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–523–0161.

SUPPLEMENTARY INFORMATION:

Background.—This investigation is being instituted as a result of an affirmative preliminary determination by the Department of Commerce that imports of fabric and expanded neoprene laminate from Taiwan are being sold in the United States at less than fair value within the meaning of section 731 of the act (19 U.S.C. 1673). The investigation was requested in a petition filed on December 23, 1986, by Rubatex Corporation, Beford, VA. In response to that petition the Commission conducted a preliminary antidumping investigation and, on the basis of information developed during the course of that investigation, determined that there was a reasonable indication that an industry in the United States was materially injured or threatened with material injury by reason of imports of the subject merchandise (52 FR 5200, February 19, 1987).

Participation in the investigation.—Persons wishing to participate in this investigation as parties must file an entry of appearance with the Secretary to the Commission, as provided in § 201.11 of the Commission's rules (19 CFR 201.11), not later than twenty-one (21) days after the publication of this notice in the **Federal Register.** Any entry of appearance filed after this date will be referred to the Chairman, who will determine whether to accept the late entry for good cause shown by the person desiring to file the entry.

Service list.—Pursuant to § 201.11(d) of the Commission's rules (19 CFR 201.11(d)), the Secretary will prepare a sevice list containing the names and addresses of all persons, or their representatives, who are parties to this investigation upon the expiration of the period for filing entries of appearance. In accordance with § 201.16(c) and 207.3 of the rules (19 CFR 201.16(c) and 207.3), each document filed by a party to the investigation must be served on all other parties to the investigation (as identified by the service list), and a certificate of service must accompany the document. The Secretary will not accept a document for filing without a certificate of service.

Staff report.—A public version of the prehearing staff report in this investigation will be placed in the public record of July 21, 1987, pursuant to § 207.21 of the Commission's rules (19 CFR 207.21).

Hearing.—The Commission will hold a hearing in connection with this investigation beginning at 9:30 a.m. on August 6, 1987, at the U.S. International Trade Commission Building, 701 E Street NW., Washington, DC. Requests to appear at the hearing should be filed in writing with the Secretary to the Commission not later than the close of

business (5:15 p.m.) on July 24, 1987. All persons desiring to appear at the hearing and make oral presentations should file prehearing briefs and attend a prehearing conference to be held at 9:30 a.m. on July 30, 1987, in room 117 of the U.S. International Trade Commission Building. The deadline for filing prehearing briefs is July 31, 1987.

Testimony at the public hearing is governed by § 207.23 of the Commission's rules (19 CFR 207.23). This rule requires that testimony be limited to a nonconfidential summary and analysis of material contained in prehearing briefs and to information not available at the time the prehearing brief was submitted. Any written materials submitted at the hearing must be filed in accordance with the procedures described below and any confidential materials must be submitted at least three (3) working days prior to the hearing (see § 201.6(b)(2) of the Commission's rules (19 CFR 201.6(b)(2))).

Written submissions.—All legal arguments, economic analyses, and factual materials relevant to the public hearing should be included in prehearing briefs in accordance with § 207.22 of the Commission's rules (19 CFR 207.22). Posthearing briefs must conform with the provisions of section 207.24 (19 CFR 207.24) and must be submitted not later than the close of business on August 13, 1987. In addition, any person who has not entered an appearance as a party to the investigation may submit a written statement of information pertinent to the subject of the investigation on or before August 13, 1987.

A signed original and fourteen (14) copies of each submission must be filed with the Secretary to the Commission in accordance with § 201.8 of the Commission's rules (19 CFR 201.8). All written submissions except for confidential business data will be available for public inspection during regular business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary to the Commission.

Any business information for which confidential treatment is desired must be submitted separately. The envelope and all pages of such submissions must be clearly labeled "Confidential Business Information." Confidential submissions and requests for confidential treatment must conform with the requirements of § 201.6 of the Commission's rules (19 CFR 201.6).

Authority: This investigation is being conducted under authority of the Tariff Act of 1930, title VII. This notice is published pursuant to § 207.20 of the Commission's rules (19 CFR 207.20).

By order of the Commission.

Issued: June 2, 1987.

Kenneth R. Mason,

Secretary.

[FR Doc. 87-13188 Filed 6-9-87; 8:45 am]

BILLING CODE 7020-02-M

[Investigation No. 337-TA-262]

Certain Hard Sided Molded Luggage Cases; Decision Not To Review Initial Determination Terminating a Respondent

AGENCY: U.S. International Trade Commission.

ACTION: Nonreview of an initial determination (ID) terminating a respondent without prejudice.

SUMMARY: The U.S. International Trade Commission has determined not to review an ID terminating without prejudice the above-captioned investigation as to respondent Eminent Enterprises, Inc. (Eminent). On April 14, 1987, complainant Samsonite Corporation moved that respondent Eminent be dismissed from the investigation without prejudice because Eminent has not and is not manufacturing, importing, or selling the subject luggage in the United States. The hard sided molded luggage manufactured and sold under the trademark "Eminent" is apparently manufactured by respondent Cosmopolitan Truck and Leather Mfg. Co., Ltd. Respondent Eminent apparently has no relationship to or interest in the Eminent luggage. The presiding administrative law judge (ALJ) issued an ID (Order No. 24) granting the motion for termination without prejudice on April 28, 1987. No petitions for review were received, nor were any comments received from other government agencies.

FOR FURTHER INFORMATION CONTACT: John Kingery, Esq., Office of the General Counsel, U.S. International Trade Commission, telephone 202-523-1638.

SUPPLEMENTARY INFORMATION: This action is taken under authority of section 337 of the Tariff Act of 1930 (19 U.S.C. 1337) and Commission rule § 210.53 (19 CFR 210.53).

Copies of the ALJ's ID and all other non confidential documents filed in connection with this investigation are available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 701 E Street NW., Washington, DC 20436, telephone 202-523-0161. Hearing-impaired individuals are advised that information on this matter can be obtained by contracting the Commission's TDD terminal on 202-724-002.

By order of the Commission.

Issued: May 29, 1987.

Kenneth R. Mason,

Secretary.

[FR Doc. 87-13189 Filed 6-9-87; 8:45 am]

BILLING CODE 7020-02-M

INTERSTATE COMMERCE COMMISSION

[No. MC-F-18176]

White Pass and Yukon Corp. Ltd.; Continuance in Control Exemption

AGENCY: Interstate Commerce Commission.

ACTION: Notice of proposed exemption.

SUMMARY: White Pass and Yukon Corporation Limited (White Pass and Yukon), a noncarrier, has filed a petition under 49 U.S.C. 11343(e). It seeks an exemption from the requirement of prior regulatory approval of its continuance in control of its wholly owned subsidiary, White Pass Transportation Limited (WPTL). WPTL is seeking authority in No. MC-194558 as a motor common carrier of general commodities (except classes A and B explosives, household goods, and commodities in bulk), between points in the United States.

WPTL is the parent company and sole owner of Canadian Motorways Ltd. (CML), a noncarrier. CML is the parent company and owner of motor carrier Motorways (1980) Limited (Motorways) (MC-110948). The acquisition of control of CML by White Pass and Yukon occurred pursuant to an exemption in No. MC-F-15443. CML also is the parent company and owner of DTSL Equity Investments Limited, a noncarrier, which in turn is the parent company and owner of noncarrier DTSL Holding Limited, which is the parent company and owner of motor carrier Direct Transportation Limited (Direct) (MC-37918). The acquisition of control of Direct by CML occurred pursuant to an exemption in MC-F-16487.

White Pass and Yukon also is the parent company and owner of White Pass Transportation, Inc., a noncarrier, which in turn is the parent company and sole owner of Pacific and Arctic Railway and Navigation Company (Pacific), which operates approximately 20 miles of railroad track between Haines, AK and White Horse, Yukon Territory, Canada. Less than 15 miles of this railroad track is in the United States. Because WPTL is affiliated with Pacific, the proposed transaction

appears to fall under *Motor Carrier Operating Authority—Railroads*, 132 M.C.C. 978 (1982).

When WPTL becomes a carrier, noncarrier White Pass and Yukon will directly control another motor carrier in addition to Motorways and Direct, as well as rail carrier Pacific. Acquisition of control of a carrier by a person that is not a carrier but controls any number of carriers may be carried out only under Commission regulation or under an exemption from regulation. *See* 49 U.S.C. 11343(a)(5) and 11343(e).

Petitioners state that regulation of the proposed exemption is not necessary to preserve the national transportation policy. They contend that granting the petition will promote safe, adequate, economical and efficient transportation, and preserve the advantages of motor carrier transportation. They contend that the proposed exemption also will encourage the establishment of a variety of price options and rates, and allow them to meet the needs of shippers and receivers while providing a more productive use of equipment and resources. Lastly, petitioners submit that regulation is not necessary to protect the public from abuse of market power.

DATES: Comments must be received by July 10, 1987.

ADDRESSES: Send comments [an original and 10 copies] referring to Docket No. MC–F–18176, to:.

(1) Office of the Secretary, Case Control Branch, Interstate Commerce Commission, Washington, DC 20423

or

(2) Petitioners' representative: Robert D. Gisvold, 16700 TCF Towers, Minneapolis, MN 55402

FOR FURTHER INFORMATION CONTACT: Judy Barnes, (202) 275–7962.

SUPPLEMENTARY INFORMATION: Petitioners seek an exemption under 49 U.S.C. 11343(e) and the Commission's regulations in *Procedures—Handling Exemptions Filed by Motor Carriers*, 367 I.C.C. 113 (1982).

A copy of the petition may be obtained from petitioners' representative, or it may be inspected at the Washington, DC Office of the Interstate Commerce Commission during normal business hours.

Decided: June 3, 1987.

By the Commission, Chairman Gradison, Vice Chairman Lamboley, Commissioners Sterrett, Andre, and Simmons. Vice Chairman Lamboley and Commissioner Simmons concurred in the result with separate expressions. Commissioner Sterrett did not participate.

Noreta R. McGee,

Secretary.

Vice Chairman Lamboley, concurring in the result:

I would exempt this transaction under 49 U.S.C. 10505 and not under 49 U.S.C. 11343(e). I continue to believe that section 11343(e) was not intended to apply and to impart antitrust immunity to such intermodal transactions.

Commissioner Simmons, concurring in the result:

I would have granted the exemption under 49 U.S.C. 10505. I do not believe 49 U.S.C. 11343(e) was intended to apply to transactions involving control of a rail carriers.

[FR Doc. 87–13180 Filed 6–9–87; 8:45 am]

BILLING CODE 7035–01–M

[Ex Parte No. 282 (Sub-No. 7)]

Special Intermodal Authority

AGENCY: Interstate Commerce Commission.

SUMMARY: The Commission is eliminating provisions [1] governing applications for special intermodal authority.[2] No applications have been filed pursuant to these provisions and specific procedures for handling such applications are unnecessary. Future applications for special intermodal authority will be processed on an *ad hoc* basis.

FOR FURTHER INFORMATION CONTACT: Joseph H. Dettmar, (202) 275–7245.

SUPPLEMENTARY INFORMATION: Additional information is contained in the Commission's decision. To purchase a copy of the full decision, write to T.S. InfoSystems, Inc., Room 2229, Interstate Commerce Commission Building, Washington, DC 20423 or call 289–4357 (DC Metropolitan area).

This decision will not significantly affect either the quality of the human environment or energy conservation. We certify that this decision will not have a significant economic impact on a substantial number of small entities, since the purpose of this decision is to eliminate provisions which no entities have used and for which there is no further administrative need.

Decided: June 2, 1987.

By the Commission, Chairman Gradison, Vice Chairman Lamboley, Commissioners Sterrett, Andre, and Simmons. Commissioner Sterrett did not participate

Noreta R. McGee,

Secretary.

[FR Doc. 87–13055 Filed 6–9–87; 8:45 am]

BILLING CODE 7035–01–M

[1] Interim rules governing applications originally appeared at 49 by CFR 1111.11. However, the rules were inadvertently removed by FCC from the Code of Federal Regulations when 49 CFR Part 1111 was amended in *Railroad Consolidation Procedures*, 366 I.C.C. 75 (1982).

[2] 49 U.S.C. 11344(e).

NATIONAL FOUNDATION ON THE ARTS AND HUMANITIES

Agency Information Collection Under OMB Review

AGENCY: National Endowment for the Humanities.

ACTION: Notice.

SUMMARY: The National Endowment for the Humanities (NEH) has sent to the Office of Management and Budget (OMB) the following proposals for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

DATES: Comments on this information collection must be submitted on or before July 10, 1987.

ADDRESSES: Send comments to Ms. Ingrid Foreman, Management Assistant, National Endowment for the Humanities, Administrative Services Office, Room 202, 1100 Pennsylvania Avenue, NW., Washington, DC 20506 (202–786–0233) and Mr. Joseph Lackey, Office of Management and Budget, New Executive Office Building, 726 Jackson Place, NW., Room 3208, Washington, DC 20503 (202–395–7316).

FOR FURTHER INFORMATION CONTACT: Ms. Ingrid Foreman, National Endowment for the Humanities, Administrative Services Office, Room 202, 1100 Pennsylvania Avenue, NW., Washington, DC 20506 (202) 786–0233 from whom copies of forms and supporting documents are available.

SUPPLEMENTARY INFORMATION: All of the entries are grouped into new forms, revisions, or extensions. Each entry is issued by NEH and contains the following information: (1) The title of the form; (2) the agency form number, if applicable; (3) how often the form must be filled out; (4) who will be required or asked to report; (5) what form will be used for; (6) an estimate of the number of responses; (7) an estimate of the total number of hours needed to fill out the form. None of these entries are subject to 44 U.S.C. 3504(h).

Category: Revisions

Title: Applications and Instruction Forms for the Tools Category

Form Number: Not applicable

Frequency of Collection: Annual
Respondents: Humanities researchers and institutions
Use: Application for funding
Estimated Number of Respondents: 92
Estimated Hours for Respondents to Provide Information: 52 per respondent
Title: Applications and Instruction Forms for the Access Category
Form Number: Not applicable
Frequency of Collection: Annual
Respondents: Humanities researchers and institutions
Use: Application for funding
Estimated Number of Respondents: 149
Estimated Hours for Respondents to Provide Information: 60 per respondent

Susan Metts,

Assistant Chairman for Administration.

[FR Doc. 87-13246 Filed 6-9-87; 8:45 am]

BILLING CODE 7536-01-M

Theater Advisory Panel (Overview Section); Meeting

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), as amended, notice is hereby given that a meeting of the Theater Advisory Panel (Overview Section) to the National Council on the Arts will be held on June 25-26, 1987, from 9:00 a.m.—5:30 p.m. in room MO-7 of the Nancy Hawks Center, 1100 Pennsylvania Avenue, NW., Washington, DC 20506.

This meeting will be open to the public on a space available basis. The topics of discussion will be guidelines, Five Year Plan and other policy issues.

If you need special accommodations dues to a disability, please contact the Office of Special Constituencies, National Endowment for the Arts, 1100 Pennsylvania Avenue, NW., Washington, DC 20506, 202/682-5532, TTY 202/682-5496 at least seven (7) days prior to the meeting.

Further information with reference to this meeting can be obtained from Mr. John H. Clark, Advisory Committee Management Officer, National Endowment for the Arts, Washington, DC 20506, or call (202) 682-5433.

John H. Clark,

Director, Council and Panel Operations, National Endowment for the Arts.

[FR Doc. 87-13198 Filed 6-9-87; 8:45 am]

BILLING CODE 7537-01-M

NUCLEAR REGULATORY COMMISSION

[Docket No. 50-321]

Georgia Power Co., et al.; Issuance of Amendment to Facility Operating License

The U.S. Nuclear Regulatory Commission (Commission) has issued Amendment No. 140 to Facility Operating License No. DPR-57, issued to Georgia Power Company, Oglethorpe Power Corporation, Municipal Electric Authority of Georgia, and City of Dalton, Georgia (the licensee), which revised the Technical Specifications for operation of the Edwin I. Hatch Nuclear Plant, Unit 1, (the facility) located in Appling County, Georgia. This amendment was effective as of the date of its issuance.

The amendment modified the Technical Specifications to delete certain valves listed in Table 3.7-4 as containment isolation valves requiring leak test, correct information errors in Table 3.7-4, and change the pressure at which main steam isolation valves are required to be tested.

The application for the amendment complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR Chapter I, which are set forth in the license amendment.

Notice of Consideration of Issuance of Amendment and Opportunity for Prior Hearing in connection with this action was published in the **Federal Register** on March 27, 1987 (52 FR 9980). No request for a hearing or petition for leave to intervene was filed following this notice.

The Commission has prepared an Environmental Assessment and Finding of No Significant Impact related to the action and has concluded that an environmental impact statement is not warranted because there will be no environmental impact attributable to the action beyond that which has been predicted and described in the Commission's Final Environmental Statement for the facility dated October 1972.

For further details with respect to the action see (1) the application for amendment dated March 4, 1987, as supplemented April 21, 1987, (2) Amendment No. 140 to License No. DPR-57, (3) the Commission's related Safety Evaluation, and (4) the Commission's related Environmental Assessment and Finding of No Significant Impact. All of these items are available for public inspection at the Commission's Public Document Room, 1717 H Street, NW, Washington, DC, and at the Appling County Public Library, 301 City Hall Drive, Baxley, Georgia 31513. A copy of items (2), (3), and (4) may be obtained upon request addressed to the U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Director, Division of Reactor Projects-I/II.

Dated at Bethesda, Maryland, this 5th day of June 1987.

Lawrence P. Crocker,

Project Manager, Project Directorate II-3, Division of Reactor Projects-I/II.

[FR Doc. 87-13263 Filed 6-9-87; 8:45 am]

BILLING CODE 7590-01-M

[Docket No. 50-286]

Power Authority of the State of New York: Consideration of Issuance of Amendment to Facility Operating License and Proposed No Significant Hazards Consideration Determination and Opportunity for Hearing

The U.S. Nuclear Regulatory Commission (the Commission) is considering issuance of amendment to Facility Operating License No. DPR-64 issued to The Power Authority of the State of New York (the licensee), for operation of Indian Point Nuclear Generating Unit No. 3, located in Westchester County, New York.

The proposed amendment would revise the Technical Specifications to allow a reduced integrated leak rate test (ILRT) duration in accordance with an NRC approved methodogy. The proposed amendment is in accordance with the licensee's application dated May 21, 1987.

The Commission has provided standards for determining whether a significant hazards consideration exists as stated in 10 CFR 50.92. A proposed amendment to an operating license for a facility involves no significant hazards consideration if operation of the facility in accordance with a proposed amendment would not: (1) Involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) Create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) Involve a significant reduction in a margin of safety.

The following analysis has been made of these changes:

1. Does the proposed license amendment involve a significant increase in the probability or

consequences of an accident previously evaluated?

The proposed license amendment does not involve any increase in the probability or consequences of an accident previously evaluated. The proposed amendment will allow use of the Bechtal Topical Report, BN-TOP-1, or other NRC accepted methods for conducting a containment ILRT. Maintaining containment leakage within acceptable limits provides assurance that the consequences of a potential accident can be effectively mitigated. Since the acceptance values for containment leakage under the reduced duration methodology remain unchanged, the consequences of accidents previously evaluated are not affected.

2. Does the proposed license amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

The proposed amendment involves methods of testing potential containment leakage. Maintaining containment leakage within acceptable limits provides assurance that the consequences of a potential accident can be effectively mitigated. Since ILRT methods and results relate to accident mitigation, event sequences and a accident analyses are not affected. Therefore, the possiblity of a new or different kind of accident is not created.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

The proposed amendment allows use of an NRC acceptable reduced duration methodology for conducting an ILRT that is equivalent to the 24 hour duration test. Under the new methodology, acceptance values for containment leakage remain unchanged and therefore a significant reduction in a margin of safety is not involved.

Based on the above, the staff proposes to determine that the proposed change does not involve a significant hazards consideration.

The Commission is seeking public comment on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination. The Commission will not normally make a final determination unless it receives a request for a hearing.

Comments should be addressed to the Rules and Procedures Branch, Division of Rules and Records, Office of Administration and Resources Management, U.S. Nuclear Regulatory Commission, Washington, DC. 20555, and should cite the publication date page number of this **Federal Register** notice.

By July 10, 1987, the licensee may file a request for a hearing with respect to issuance of the amendment to the subject facility operating license and any person whose interest may be affected by this proceeding and who wishes to participate as a party in the proceeding must file a written petition for leave to intervene. Request for a hearing and petitions for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10 CFR Part 2. If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or an Atomic Safety and Licensing Board, designated by the Commission or by the Chairman of the Atomic Safety and Licensing Board Panel, will rule on the request and/or petition and the Secretary or the designated Atomic Safety and Licensing Board will issue a notice of hearing or an appropriate order.

As required by 10 CFR 2.714, a petition for leave to intervene shall set forth with particularly the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention would be permitted with particular reference to the following factors: (1) The nature of the petitioner's right under the Act to be made a party to the proceeding; (2) the nature and extent of the petitioner's property, financial, or other interests in the proceeding; and (3) the possible effect of any order which may be entered in the proceeding on the petitioner's interest. The petition should also identify the specific aspect(s) of the subject matter of the proceeding as to which petitioner wishes to intervene. Any person who has filed a petition for leave to intervene or who has been admitted as a party may amend the petition without requesting leave of the Board up to fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, but such an amended petition must satisfy the specificity requirements described above.

Not later than fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, a petitioner shall file a supplement to the petition to intervene which must include a list of the contentions which are sought to be litigated in the matter, and the bases for each contention set forth with reasonable specificity. Contentions shall be limited to matters within the scope of the amendment under consideration. A petitioner who fails to file such a supplement which satisfies these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing, including the opportunity to present evidence and cross-examine witnesses.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determinaton will serve to decide when the hearing is held.

If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it effective notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment.

If the final determination is that the amendment involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

Normally, the Commission will not issue the amendment until the expiration of the 30-day notice period. However, should circumstances change during the notice period such that failure to act in a timely way would result, for example, in derating or shutdown of the facility, the Commission may issue the license amendment before the expiration of the 30-day notice period, provided that its final determination is that the amendment involves no significant hazards consideration. The final determination will consider all public and State comments received. Should the Commission take this action, it will publish a notice of issuance and provide for opportunity for a hearing after issuance. The Commission expects that the need to take this action will occur very infrequently.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Docketing and Service Branch, or may be delivered to the Commission's Public Document Room, 1717 H Street, NW., Washington, DC, by the above date. Where petitions are filed during the last ten (10) days of the notice period, it is requested that the petitioner promptly so inform the Commission by a toll-free telephone call to Western Union at (800) 325-6000 (in Missouri (800) 342-6700). The Western Union operator should be

given Datagram Identification Number 3737 and the following message addressed to Robert A. Capra, Acting Director, Project Directorate I–1, Division of Reactor Projects, I/II: petitioner's name and telephone number; date petition was mailed; plant name; and publication date and page number of this **Federal Register** notice. A copy of the petition should also be sent to the Office of the General Counsel—Bethesda, U.S. Nuclear Regulatory Commission, Washington, DC 20555 and Mr. Charles M. Pratt, 10 Columbus Circule, New York, New York 10019, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the presiding Atomic Safety and Licensing Board, that the petition and/or request should be granted based upon a balancing of factors specified in 10 CFR 2.714(a)(1) (i)–(v) and 2.714(d).

For further details with respect to this action, see the application for amendment which is available for public inspection at the Commission's Public Document Room, 1717 H Street, Washington, DC, and at the White Plains Public Library, 100 Martine Avenue, White Plains, New York.

Dated at Bethesda, Maryland, this 5th day of June, 1987.

For the Nuclear Regulatory Commission.

Robert A. Capra,

Acting Director, Project Directorate I–1, Division of Reactor Projects, I/II.

[FR Doc. 87–13264 Filed 6–9–87; 8:45 am]

BILLING CODE 7590–01–M

SECURITIES AND EXCHANGE COMMISSION

Forms Under Review of Office of Management and Budget

Agency Clearance Officer: Kenneth A. Fogash, (202) 272–2142

Upon Written Request Copy Available From: Securities and Exchange Commission, Office of Consumer Affairs and Information Services, 450 Fifth Street, NW., Washington, DC 20549

New

Rule 19b–1 [17 CFR 270.19b–1]

File No. 270–312

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1940 [44 U.S.C. 3501 *et seq.*], the Securities and Exchange Commission has submitted for clearance proposed amendments to rule 19b–1 to allow certain registered investment companies to make additional distributions of long-term capital gains with respect to a taxable year without violating section 19(b) of the Investment Company Act of 1940 [15 U.S.C. 80a–19(b)] or rule 19b–1 [17 CFR 270.19b–1] thereunder.

Comments should be submitted to OMB Desk Officer: Mr. Robert Neal, Office of Information and Regulatory Affairs, Room 3228, NEOB, Washington, DC 20503.

Shirley E. Hollis,

Assistant Secretary.

June 4, 1987.

[FR Doc. 87–13256 Filed 6–9–87; 8:45 am]

BILLING CODE 8010–01–M

[Release No. 34–24538; File No. SR–CBOE–87–20]

Self-Regulatory Organizations; Proposed Rule Change by the Chicago Board Options Exchange, Inc.; Relating to Exchange Investigations

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934, 15 U.S.C. 78s(b)(1), notice is hereby given that on May 7, 1987 the Chicago Board Options Exchange, Inc. ("Exchange") filed with the Securities and Exchange Commission the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Text of the Proposed Rule Change

The Exchange has filed a proposed rule change which provides that a failure to furnish testimony or other evidence requested by the Exchange during an inquiry or an investigation on the date or in the time period specified will be presumed to be obstructive of an Exchange inquiry or an investigation, in violation of Exchange Rule 17.2.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below and is set forth in sections (A), (B), and (C) below.

(A) Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

The proposed rule change specifies that the Exchange has the ability to require members and persons associated with members to give testimony, documentary evidence or other information in the course of Exchange investigations and inquiries within specified periods of time. At the same time, by stating that a late response creates only a presumed violation, the rule would allow mitigating circumstances to be considered.

The purpose of the proposal is to assure that the Exchange has the ability to require timely submissions of information in conjunction with any inquiry or investigation by the Exchange including, in particular, violations concerning insider trading and frontrunning.

The Exchange believes that this new interpretation to Exchange Rule 17.2 will enhance the Exchange's ability to investigate possible violations within the Exchange's disciplinary jurisdiction and to accomplish a prompt disposition of pending matters. The Exchange believes that the proposed rule change is consistent with the provisions of the Securities Exchange Act of 1934 and, in particular, sections 6(b)(1) and 6(b)(5) of the Act, in that the provisions are designed to strengthen the Exchange's disciplinary process.

(B) Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that this proposed rule change will impose any burden on competition.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants or Others

Comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by July 1, 1987.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.

Dated: June 3, 1987.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13209 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-24539; File No. SR-CBOE-87-9]

Self-Regulatory Organizations; Chicago Board Options Exchange, Inc. Order Approving Proposed Rule Change

On March 16, 1987, the Chicago Board Options Exchange, Inc., ("CBOE") submitted to the Securities and Exchange Commission ("Commission"), pursuant to section 19(b)(1) under the Securities Exchange Act of 1934 ("Act") [1] and Rule 19b-4 thereunder,[2] a proposed rule change to add a third out-of-the-money strike price to classes of index options traded on the Exchange.

The proposed rule change was noticed in Securities Exchange Act Release No. 24345, April 15, 1987. No comments were received on the proposed rule change.

The proposed rule change will provide flexibility for the CBOE to add series of index option contracts at sufficient price intervals away from the existing index value to allow appropriate trading strategies to be effectuated.

In recent days, the index value in the S&P 100 Index Options ("OEX") has, on an intra-day basis, moved as many as 13 points. This volatile price movement results in two particularly acute problems in trading. First, the volatility dramatically increases the prices of the existing options, thereby limiting the ability to hedge with lower priced options. Second, the process for introduction of new strikes requires some degree of lead time and consequently relief cannot be offered to the marketplace rapidly enough to deal with this circumstance.

The Exchange has previously secured some relief in this area (*See* SR-CBOE-84-22, as amended). As approved by the Commission, the referenced proposed rule change allows for the maintenance of two out-of-the-money strike prices in index options, and a third can be added in unusual market conditions. This relief, however, has been inadequate to deal with the increasing circumstances wherein index options trade through a substantial number of strike prices on a very short-term basis. The Exchange believes that the addition of an additional out-of-the-money strike price interval in unusual market conditions is an appropriate step.

The Commission finds that the proposed rule change is consistent with the Act and in particular the requirements of Section 6 and the Rules and Regulations thereunder in that the proposed rule change will accommodate market participants' investment needs and objectives, increase market depth and liquidity and improve the market's efficiency. It should also be noted that the CBOE does not believe that the increased number of strike prices will impair market efficiency by dispersing trading activity. To the contrary, the Exchange believes that market participants are enabled, by hedging activity in the additional strike prices, to assume greater positions in the preexisting option series.

It is therefore ordered, pursuant to section 19(b)(2) of the Act,[3] that the proposed rule change is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[4]

Dated: June 3, 1987.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13210 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-24533; File No. SR-DTC-87-08]

Self-Regulatory Organizations; Depository Trust Co.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (the "Act"), 15 U.S.C. 78(b)(1), notice is hereby given that on April 30, 1987, the Depository Trust Company ("DTC") filed with the Securities and Exchange Commission ("Commission") the proposed rule change described below. The proposal consists of a new fee to be charged when participants fail to execute DTC eligibility certificates. The Commission is publishing notice to solicit comment on the rule change.

DTC states in its filing that it is imposing a new fee, which is a combination of the current Certificate on Demand ("COD") fee plus $100.00. The fee is to be charged under certain circumstances (described below) when participants fail to execute DTC eligibility certificates.

DTC holds all certificates in the name of its nominee, Cede & Co. For certain categories of issues (*e.g.* selected limited partnerships and maritime securities), DTC must make certain representations to the issuer before DTC can obtain certificates in its nominee name. For example, DTC must certify that it is not holding the issue on behalf of someone who is ineligible to hold the security. DTC requires that participants provide it with the necessary certificates to avoid the potential liability it, and the participant, would face from improperly holding a security, DTC has found that sometime participants fail to execute these certifications.

In order to encourage participants to submit the required certifications to DTC, DTC intends to review all accounts on a weekly basis to determine if participants that have failed to submit certifications nonetheless are maintaining positions in issues requiring certifications. When DTC indentifies such positions, it will forward the entire position to the participant as a COD withdrawal and charge the new combined fee of $100.00 plus the COD fee.

DTC stated it has adopted the proposed rule change pursuant to section 17A(b)(3)(D) of the Act which

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[1] 15 U.S.C. 78s(b)(1) (1982).

[2] 17 CFR 240.19b-4 (1985).

[3] 15 U.S.C. 78s(b)(2) (1982).

[4] 17 CFR 200.30-3(a)(12) (1985).

authorizes DTC to adopt reasonable fees for the services which it provides. DTC believes the proposed rule change promotes the prompt and accurate clearance and settlement of securities transactions by permitting DTC to make its service eligible to more categories of issuers.

The rule changes has become effective pursuant to section 19(b)(3)(A) of the Act and Rule 19b-4. The Commission may summarily abrogate the rule change at any time within 60 days of its filing if it appears to the Commission that abrogation is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

You may submit written comment within 21 days after notice is published in the **Federal Register**. Please file six copies of your comment with the Secretary of the Commission, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, with accompanying exhibits, and all written comments, except for material that may be withheld from the public under 5 U.S.C. 552, are available at the Commission's Public Reference Room, 450 Fifth Street, NW., Washington, DC. Copies of the filing also will be available for inspection and copying at the principal office of DTC. All submissions should refer to File No. SR-DTC-87-08.

For the Commission, by the Division of Market Regulation pursuant to delegated authority.

Dated: June 1, 1987.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13211 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-24536; File No. SR-MCC-87-01]

Self-Regulatory Organizations; Midwest Clearing Corp.; Order Approving Proposed Rule Change

The Midwest Clearing Corporation ("MCC") on February 27, 1987, filed a proposed rule change with the Commission under section 19(b)(1) of the Securities Exchange Act ("Act"). As explained in greater detail below, the proposal authorizes MCC to establish procedures for the automated transfer and processing of customers' security accounts. The Commission published notice of the proposal in the **Federal Register** on March 23, 1987, to solicit public comment.[1] No public comment was received. This order approves the proposal.

I. Description

The proposal authorizes MCC to establish procedures for the automated transfer and processing of customer securities accounts on behalf of MCC participants.[2] The procedures would include the establishment of time periods and regulations for the automated transfer of a participant's customer securities accounts, including: Transfer initiation forms, instructions, reports to participants, and any information required by MCC to transfer a securities account from one clearing agency participant to another participant. Further, MCC would be authorized to adopt procedures concerning acceptances or rejections of customer account transfers and the transfer of items in customer accounts through its Continuous Net Settlement ("CNS") System or Trade-by-Trade System.[3]

MCC further states that it currently is drafting rules of implementation for this enabling proposal. The implementation rules essentially will deal with operations, procedures, and forms. Moreover, MCC already has initiated a pilot account transfer program and estimates that it would be ready to exapnd to a full-scale transfer program in June 1987.[4]

The proposal provides that MCC would not be liable for the completeness or accuracy of the information contained in a participant's documentation or in its request to transfer a customer's securities account through the facilities of MCC or otherwise, or for the completeness or accuracy of any documentation necessary for a participant to transfer a customer securities account or for the validity of information regarding any particular asset contained in a customer securities account. MCC states that its sole responsibility would be to make any transfer initiation documentation or information forms available to the delivering participant who is to transfer the account or to return such forms to the receiving participant to whom the account is to be transferred.[5]

II. MCC's Rationale

The purpose of the proposal is to allow transfers of customer securities accounts among MCC participants, and between an MCC participant and a participant in another registered clearing agency that has established an automated account transfer service. MCC states that the proposal would provide the necessary enabling authority for MCC to establish procedures for automated account transfer service, including applicable forms, reports, instructions, or other necessary information and data. MCC also states that the proposal is consistent with the act because it would facilitate the prompt and accurate clearance and settlement of securities transactions, including customer account transfers.

III. Discussion

The Commission believes that MCC's proposal is consistent with the Act. The Commission believes that the proposal would promote the timely and accurate transfer of customers' securities accounts in accordance with section 17A of the Act and, more particularly, that the use of automated procedures for transferring accounts would enhance efficiency and reduce expenses in account transfer processing. The proposal also should help to reduce, for depository-eligible securities, the manually intensive handling of securities certificates and related paperwork between broker-dealers.

The Commission notes that an automated customer account transfer system ("ACATS") is already in effect at NSCC.[6] Additionally, self-regulatory organizations, including the New York Stock Exchange, require member organizations dealing with the public to use ACATS for customer account transfers.[7]

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[1] *See* Securities Exchange Act Release No. 24218 (March 16, 1987) 52 FR 9239.

[2] MCC would provide services primarily to Midwest Stock Exchange ("MSE") members and MCC participants that are not members of the National Securities Clearing Corporation ("NSCC").

[3] MCC states in its filing that NSCC has agreed to serve as the facilities manager for the proposal. MCC would accept the transfer information requests from its clearing firms and transmit the information on tape to NSCC for processing. NSCC would do the actual processing and would give MCC the output (the results of the processing). MCC would then furnish the reports to its clearing firms.

[4] MCC plans to file its rules of implementation pursuant to Section 19(b)(3)(A) of the Act. Telephone conversation between Jeffery E. Lewis, Associate Counsel, MCC, and Thomas C. Etter, Attorney, Securities and Exchange Commission, May 11, 1987.

[5] The proposal would not affect MCC's liability for establishing CNS positions which are governed by Article III, Rules 1-4, of MCC's existing rules. Telephone conversation between Jeffrey E. Lewis, Associate Counsel, MCC and Thomas C. Etter, Securities and Exchange Commission, May 12, 1987.

[6] *See* Securities Exchange Act Release No. 22481 (September 30, 1985), 50 FR 41274.

[7] *See* Securities Exchange Act Release No. 22913 (February 14, 1986); and Securities Exchange Act Release No. 22662 (November 26, 1985), 50 FR 49643. The MSE also has filed a proposal to require its

Continued

The Commission also notes that MCC's proposal includes disclaimers of MCC responsibility for, among other things, the accuracy or completeness of instructions or reports for customer account transfers. The Commission believes those disclaimers are appropriate because MCC generally would not be in a position to monitor those documents for completeness or accuracy. Under the proposal, MCC would act simply as intermediary in relaying account transfer information to NSCC and among participants. The proposal does not alter MCC's higher standard of care applicable to the safeguarding of securities and funds. Accordingly, the Commission believes that MCC's standard of care under the proposal is consistent with the Act.[8]

The Commission recognizes that the proposal authorizes MCC to establish procedures for the ACATS services and provides a framework for that service in MCC's rules. Accordingly, MCC must file its procedures for review under the Act before initiating any customer account transfer on behalf of MCC members.

IV. Conclusion

For the reasons discussed above, the Commission finds that the proposal is consistent with the requirements of the Act and, in particular, with section 17A and the rules and regulations thereunder.

It is therefore ordered, pursuant to section 19(b)(2) of the Act, that the above-mentioned proposed rule change (File No. SR-MCC-87-01) be, and hereby is, approved.

For the Commission, by the Division of Market Regulation pursuant to delegated authority.

Dated: June 2, 1987.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13212 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-24551; Filed No. SR-NYSE-87-3]

Self-Regulatory Organizations; New York Stock Exchange, Inc., Order Approving Proposed Rule Change

The New York Stock Exchange, Inc. ("NYSE") submitted on February 9, 1987 copies of a proposed rule change pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act") and Rule 19b-4 thereunder to reflect the NYSE's current use and commitment to future use of the Uniform Application for Securities Industry Registration or Transfer ("Form U-4") as part of its registration and oversight of member organization personnel.

Notice of the proposed rule change together with the terms of substance of the proposed rule change was given by the issuance of a Commission release (Securities Exchange Act Release No. 24395, April 27, 1987) and by publication in the **Federal Register** (52 FR 16012, May 1, 1987). No comments were received with respect to the proposed filing.

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations applicable thereunder to the NYSE, and, in particular, the requirements of section 6 and the rules and regulations thereunder.

It is therefore ordered, pursuant to section 19(b)(2) of the Act, that the above-mentioned rule change be, and hereby is, approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority, 17 CFR 200.30-3(a)(12).

Dated: June 4, 1987.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13213 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-24537; File No. Phlx-86-28 and 87-6]

Self-Regulatory Organizations; Order Approving Proposed Rule Change and Notice of Filing and Order Granting Accelerated Approval To Proposed Rule Change by the Philadelphia Stock Exchange, Inc., Relating to an Amendment to Its By-Laws Concerning Non-Member Arbitration

The Philadelphia Stock Exchange, Inc. ("Phlx" or "Exchange") submitted on August 27, 1986 copies of a proposed rule change [1] pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 ("Act") 15 U.S.C. 78s (b)(1) and Rule 19b-4 thereunder to amend Rule 950 of its Rules of Board of Governors. The proposal amends Phlx arbitration provisions so that the only non-members that can initiate arbitration proceedings against a member are public customers and equitable titleholders of an Exchange membership or participation.

On March 3, 1987, the Phlx also filed with the Commission, a proposed rule change [2] to amend By-Law Article X, Sec. 10-8(b) so that it conformed to its proposed amendment to Rule 950.[3]

As noted above, the proposed amendments to Rule 950 and section 10-8(b) of the Exchange By-Laws would amend Phlx's arbitration rules so that the only non-member to member disputes that could be arbitrated under Phlx rules are actions initiated by public customers and equitable titleholder of an Exchange membership or participation. In its filing (SR-Phlx-86-28), the Phlx indicated that the purpose of the change is to clarify that non-member refers only to equitable titleholders who are not legal members and, therefore, cannot initiate arbitration proceedings under the member to member dispute provisions. As proposed the amended rule and By-law would result in eliminating any possibility that non-member employees of member firms can arbitrate a dispute with their employer under Phlx rules.

Notice of proposed rule change SR-Phlx-86-28 together with its terms of substance was given by the issuance of a Commission release (Securities Exchange Act Release No. 23627, September 19, 1986) and by publication in the **Federal Register** (51 FR 34513, September 20, 1986). No comments were received regarding the proposal.

The Commission finds that proposed rule change SR-Phlx-86-28 is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange and, in particular, the requirements of Section 6, and the rules and regulations thereunder. In this regard, the Phlx rule filing clarifies the parties permitted to use the Exchange's arbitration facilities. This should eliminate any confusion over the availability of these facilities, while continuing to make the facilities available to public customers.

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members to use automated clearing agency systems to effect customer account transfers. *See* File No. SR-MSE-87-05.

[8] *See, e.g.*, Securities Exchange Act Release No. 16900 (June 17, 1980), 45 FR 41920; Securities Exchange Act Release No. 22940 (February 24, 1986), 51 FR 7169.

[1] SR-Phlx-86-28.

[2] SR-Phlx-87-6.

[3] Article X, sec. 10-8(b) would be amended as follows Section 10-8(b) [Non-Member] *Public Customer or Equitable Titleholder* Controversies: Any dispute, claim or controversy between a *public* customer or [non-member] *equitable titleholder of an Exchange membership or participation* and a member, member organization and/or associated person in connection with the securities business of such member, member organization and/or associated person in connection with his activities as an associated person shall be arbitrated under Rule 950. [For purposes of this Section, the term non-member shall not be deemed to include a foreign currency option participant.]

The Commission finds good cause for approving proposed rule change SR-Phlx-87-6 prior to the thirtieth day after the date of publication of notice thereof in that the change in the By-law is necessary to ensure consistency between the proposed amendment to Exchange Rule 950 and the proposed amendment to Section 10-8(b) of the Exchange By-Laws.[4] Accordingly, the Commission believes that it is appropriate to approve the proposed rule change to the By-law on an accelerated basis so that it will be consistent with Rule 950.

It is Therefore Ordered, pursuant to section 19(b)(2) of the Act, that the proposed rule change referred to above be, and hereby are, approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[5]

Dated: June 2, 1987.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13208 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and of Opportunity for Hearing, of Midwest Stock Exchange, Inc.

June 3, 1987.

The above named national securities exchange has filed applications with the Securities and Exchange Commission pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder, for unlisted trading privileges in the following securities:

Broken Hill Proprietary Co., Ltd. (The)
The American Depositary Shares each representing 4 Ordinary Shares (File No. 7-0181)

Burger King Investors Master L.P. II
Depositary Receipts Representing Units of Limited Partnership Interests (File No. 7-0182)

Cineplex Odeon Corporation
Common Stock, No Par Value (File 7-0183)

MFS Government Market Income Trust
Shares of Beneficial Interest, No Par Value (File No. 7-0184)

Blocker Energy Corporation
Common Stock, $.10 Par Value (File No.7-0185)

Alza Corporation
Common Stock, $1.00 Par Value (Eile No. 0186)

British Gas PLC
Second Interim Depositary Receipts (File No. 7-0187)

Ideal Basic Industries, Inc. (The)
Common Stock, $5.00 Par Value (File No. 7-0188)

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before June 24, 1987 written data, views and arguments concerning the above-referenced applications. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the applications if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13214 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications of Philadelphia Stock Exchange, Inc., for Unlisted Trading Privileges and of Opportunity for Hearing

June 3, 1987.

The above named national securities exchange has filed applications with the Securities and Exchange Commission pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder, for unlisted trading privileges in the following securities:

Western Digital Corporation (Delaware)
Common Stock, $0.10 Par Value (File No. 7-0179)

Wisconsin Energy Corporation (Holding Company)
Common Stock, $10.00 Par Value (File No. 7-0180)

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before June 24, 1987, written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13215 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

[Rel. No. IC-15769; 812-6663]

Jet Capital Corp.; Notice of Application and Temporary Order

June 3, 1987.

AGENCY: Securities and Exchange Commission ("SEC").

ACTION: Notice of Application for an Order under the Investment Company Act of 1940 (the "1940 Act"); and Order of Temporary Exemption.

Applicant: Jet Capital Corporation ("Jet" or "Applicant").

Relevant 1940 Act Section: Order requested under section 3(b)(2) of the 1940 Act and temporary order granted under section 6(c) from all provisions of the 1940 Act.

Summary of Application: Applicant seeks an order declaring it to be primarily engaged in a business other than that of investing, reinvesting, owning, holding or trading in securities. Applicant further requests a tempoary order exempting it from all provisions of the 1940 Act during the period from May 18, 1987, until the Commission shall make a final determination upon the application.

Filing Date: The application was filed March 25, 1987, and amended on May 18, 1987, and June 3, 1987.

Hearing or Notification of Hearing: If no hearing is ordered, an order granting the application will be issued. Any interested person may request a hearing on this application, or ask to be notified if a hearing is ordered. Any requests must be received by the SEC no later than 5:30 p.m., on June 26, 1987. Requests must be in writing, setting forth the nature of your interest, the reasons for the request, and the issues contested. Applicant should be served with a copy of the request, either personally or by

[4] We note that the change to Rule 950 was noticed and we received no public comment.

[5] 17 CFR 200.30-3.

mail, and the request should also be sent to the Secretary of the SEC, along with proof of service (by affidavit or, in the case of an attorney-at-law, by certificate). Notification of the date of a hearing should be requested by writing to the Secretary of the SEC.

ADDRESSES: Secretary, SEC, 450 Fifth Street, NW., Washington, DC 20549; Applicant, 800 Third Avenue, New York, New York 10022.

FOR FURTHER INFORMATION CONTACT: Special Counsel Curtis R. Hilliard (202) 272–3026, Office of Investment Company Regulation.

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application is available for a fee from either the SEC's Public Reference Branch in person or the SEC's commercial copier (800) 231–3282 (in Maryland (301) 258–4300).

Applicant's Representations:

1. Jet was incorporated in 1969, and, since 1972, Jet's principal business has been the direction and control of Texas Air Corporation ("Texas Air"), a holding company with wholly-owned subsidiaries which are engaged in airline and airline related businesses. As of the date of the filing of this application, Jet's principal assets (representing more than 90% of Jet's total assets on a market value basis) consist of 253,650 shares of Texas Air Common Stock and 2,040,000 shares of Texas Air Class A Common Stock. Jet's Common Stock (its only outstanding security) is currently owned by fewer than 100 holders of record. Approximately 62% of the outstanding Common Stock of Jet is owned by Jet's officers and directors, and approximately 49% is owned by Francisco A. Lorenzo, Jet's Chairman and Chief Executive Officer.

2. Texas Air is a holding company, the principal holdings of which are all of the common stock of Continental Airlines, Inc. ("Continental"), Eastern Air Lines, Inc. ("Eastern"), People Express, Inc. ("People Express"), Frontier Holdings, Inc. ("Frontier"), New York Airlines, Inc. ("New York Air"), three commuter airlines and SystemOne Holdings, Inc. ("SystemOne"). Texas Air manages the business operated by its subsidiaries through its control of their boards of directors and its control over the appointment of their executive officers. Texas Air also engages in the equipment leasing business directly and through its subsidiary, Texas Air Leasing, and engages in the business of marketing airline reservations and computer processing systems through its SystemOne subsidiary. Jet has been the principal stockholder of Texas Air since 1972, as measured by voting power.

3. Jet proposes to diversify its business beyond the airline and airline-related businesses it currently manages through Texas Air by acquiring other business which it will operate either directly or through majority-owned subsidiaries. In addition to acquiring majority positions in businesses outside the airline and airline-related industies, Jet may engage in airline-related businesses directly and may purchase additional controlling positions in companies engaged in airline and airline-related businesses. It is expected that this acquisition program will be financed with additional capital obtained from lending institutions or from outside investors.

4. The Texas Air Common Stock and Class A Common Stock owned by Jet represent less than 50% of the outstanding voting securities of Texas Air. Accordingly, the Texas Air securities held by Jet fall within the definition of "investment securities" set forth in section 3 of the 1940 Act. Because these Texas Air securities constitute more than 40% of Jet's total assets, Jet, absent an exemption, would fall within the definition of "investment company" set forth in section 3(a)(3) of the 1940 Act. Although Jet believes it is currently exempt, any uncertainty about Jet's status under the 1940 Act could impair Jet's ability to raise the capital necessary to finance its proposed diversification program. This Application is submitted for an order pursuant to section 3(b)(2) of the 1940 Act to eliminate any questions about Jet's status.

Applicant's Legal Conclusion:

1. Applicant believes that Jet controls Texas Air within the meaning of the Act. As more fully described in the application, Jet believes that it controls Texas Air becasue of:

(i) The historical relationship between Jet and Texas Air;

(ii) Jet being the single largest stockholder of Texas Air as measured by voting power, (approximately 34% of the votes at meetings of Texas Air stockholders);

(iii) Jet's represntation on Texas Air's board of directors (4 of 11 directors) and the fact that officers and directors of Jet constitute the entire executive committee of the Texas Air board; and

(iv) The fact that since 1972, key executive positions of Texas Air (including the positions of Chief Executive Officer and, since 1976, Chief Financial Officer) have been, and are at this time, occupied by officers and directors of Jet.

2. Jet not only controls Texas Air, but also is primarily engaged in the airline business and airline-related businesses through Texas Air, and after implementation of the diversification program will continue to be primarily engaged in the airline business and airline-related businesses. Historically, Jet has not engaged in any significant business other than the airline business through Texas Air. Jet was established in 1969 to operate an aircraft leasing business, but that venture was frustrated in 1970 with the onset of a recession which impaired Jet's ability to finance the acquisition of aircraft. Jet quickly turned to the airline business, and by 1972 had taken control of Texas Air. Since that time, Jet has been primarily engaged in the airline and airline-related businesses and its officers have devoted all their business time to the business of Texas Air.

3. The vast proponderance of Jet's assets consists of securities of Texas Air. These securities represented approximately 69.0% of Jet's total assets on a book value basis at December 31, 1986 and approximately 92.4% on a market value basis. These assets have not changed materially since that date. Jet has participated from time to time in certain partnerships with Texas air which acquired securities of Eastern and certain other compaines in connection with Texas Air's acquisition program. These holdings have not exceeded 22.6% of Jet's total assets on a market value basis at any time.

4. Substantially all of Jet's net income (approximately 95% in 1985 and 1986) is derived from Jet's holdings of Texas Air securities. Texas Air has not paid a cash dividend since mid-1983, and the income reflected in Jet's income statement for 1985 and 1986 is based primarily on Jet's proportionate interest in the income and stockholder's equity of Texas Air. At this time, Jet has no significant income from any other source. Jet realized approximately $481,000 of income in 1986 from its participation in the acquisition partnerships referred to above. This income represented less than 8% of Jet's net income in 1986.

5. Over its history, Jet has typically had only three officers: a Chairman, a President and a Secretary/Treasurer, each of whom has devoted substantially all his business time to the business of Texas Air. At this time, Francisco A. Lorenzo and Robert Sendeker, Jet's Chairman and Secretary/Treasurer, respectively, devote their full business attention to Texas Air in their capacities as directors and executive officers of Texas Air. Jet has recently engaged Kevin S. Moore who serves as President

and Chef Operating officer of Jet and as Director of Business Development for Texas Air. It is expected that Mr. Moore will devote the major portion of his business time to the managment of Jet's diversification program, which is described below, and to the managment of the companies to be acquired by Jet in connection with that program. Further, since 1972 Jet has consistently represented itself as a holding company whose principal assets are the securities of Texas Air. Jet has never represented or held itself out as an investment company.

6. As described above, Jet is primarily engaged in a non-investment company business through Texas Air. Jet proposes to diversify its business beyond its existing airline and airline-related business by undertaking a newly-formulated expansion and acquisition program. Jet proposes to acquire majority positions in companies outside of the airline and airline-realted industries. These acquisitions may be made through leveraged buyout transactions, open-market purchases of stock, tender offers, mergers or other means. It is expected that holding in non-airline-related businesses ultimately may exceed 50% of Jet's total assets. Although this diversification program may result in significant changes in Jet's overall businesses, Jet expects that it will continue to be primarily engaged in the airline business and airline-related businesses.

7. It is expected that the diversification program will be financed with additional capital obtained from lending institutions or from outside investors, or, when the business permits, with internally generated funds. Although Jet has from time to time sold Texas Air securities to cover various expenses, Jet does not intend to sell any of its Texas Air securities to finance the diversification program.

8. Jet will retain indefinitely the majority positions that it expects to acquire and will derive a profit from the earnings of the businesses rather than from the disposition of the businesses after they have appreciated in value. Jet and its personnel will participate actively in the management of the companies which it acquires.

Applicant's Condition:

In order to ensure that Jet will continue to be primarily engaged in the airline business and airline-related businesses upon implementation of the diversification program, Jet has agreed to the following condition being attached to any order granted on this application:

1. Jet will not acquire any "investment securities" if at the time or as a result of such acquisition the value of investment securities held by Jet would exceed 40% of Jet's total assets, except as permitted by law (such percentage will be computed on an unconsolidated basis and for purposes of computing such percentage and applying any exemption or exception based on Jet's holdings of investment securities, "investment securities" will include all securities defined as "investment securities" under the 1940 Act other than securities issued by companies in the airline business or airline-related businesses, including Texas Air, which are directly or indirectly controlled by Jet).

Temporary Order

The request for temporary exemptive relief pending a final determination on the application by the Commission has been considered, and it is found that, in view of the circumstances set forth above and in the Application, that it is appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the 1940 Act to grant an immediate temporary order as requested by Applicant. Accordingly,

It Is Ordered, pursuant to section 6(c) of the 1940 Act, that the Application for a temporary order exempting Applicant from all provisions of the 1940 Act be, and hereby is, granted, during the period from May 18, 1987 until the Commission shall make a final determination upon the request for exemption set forth in the Application, subject to the undertakings to which Applicant has consented and which are set forth above and in the application.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13207 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 35-24404]

Filings Under the Public Utility Holding Company Act of 1935 ("Act")

June 4, 1987.

Notice is hereby given that the following filing(s) has/have been made with the Commission pursuant to provisions of the Act and rules promulgated thereunder. All interested persons are referred to the application(s) and/or declaration(s) for complete statements of the proposed transaction(s) summarized below. The application(s) and/or declaration(s) and any amendment(s) thereto is/are available for public inspection through the Commission's Office of Public Reference.

Interested persons wishing to comment or request a hearing on the application(s) and/or declaration(s) should submit their views in writing by June 29, 1987 to the Secretary, Securities and Exchange Commission, Washington, DC 20549, and serve a copy on the relevant applicant(s) and/or declarant(s) at the addresses specified below. Proof of service (by affidavit or, in case of an attorney at law, by certificate) should be filed with the request. Any request for hearing shall identify specifically the issues of fact or law that are disputed. A person who so requests will be notified of any hearing, if ordered, and will receive a copy of any notice or order issued in the matter. After said date, the application(s) and/or declaration(s), as filed or as amended, may be granted and/or permitted to become effective.

Enron Corp. (31-821)

Enron Corp. ("Enron"), 1400 Smith, Houston, Texas 77002, has filed an application for an order declaring that it is not a gas utility company under Section 2(a)(4) of the Act because: (1) It is primarily engaged in businesses other than that of a gas utility company and (2) it distributes at retail only a small amount of natural or manufactured gas.

Enron, a Delaware corporation, has four principal business segments: (1) Transmission of natural gas at wholesale; (2) natural gas and oil exploration and production primarily in the United States and Canada; (3) acquisition, production, transportation, and marketing of natural gas liquids and petroleum products; and (4) production and marketing of plastic resins and films, petrochemicals, and antifreeze. Enron's common stock is registered under section 12(b) of the Securities Exchange Act of 1934. Approximately 19% of said stock is owned by the Enron Corp. Employee Stock Ownership Plan.

Enron's operating revenues from natural gas sales were approximately $2.7, $4.2, and $4.1 billion, respectively, for calendar years 1984, 1985, and 1986 and were derived principally from direct sales to electric utility and industrial customers; sales of gas for resale; and transportation of gas for others. During 1984, 1985, and 1986, Enron had consolidated operating revenues of approximately $7.0, $9.7, and $7.6 billion, respectively, and net income applicable to common stock of $217.2 million in 1984, net loss of $103.2 million in 1985, and net income of $9.4 milion in 1986. Enron had consolidated total

assets of approximately $5.9, $9.6, and $8.5 billion, respectively, at December 31, 1984, 1985, and 1986.

Enron, through its divisions, Northern Natural Gas Company ("Northern") and San Juan Gas Company ("SJGCo"), engages in retail sales of gas. Northern's retail sales are made under "farm tap" clause arrangements with 82 rural landowners (3 in Oklahoma, 76 in Montana, and 3 in Kansas) in exchange for right-of-way grants. During 1984, 1985, and 1986, retail sales constituted approximately .001%, or $23,000, .003%, or $73,000, and .003%, or $60,000, respectively, of Enron's total gas sales.

SJGCo was acquired by Enron in January 1985, is regulated by the Public Service Commission of Puerto Rico, and supplies gas to approximately 12,000 residential, public-housing, commercial, industrial, and government customers located in San Juan, Puerto Rico. SJGCo's revenues for 1984, 1985, and 1986 were approximately $5,030,134, $4,861,137, and $4,845,981, respectively. Retail sales, through SJGCo, constituted approximately .1% or $4,752,000, and .1%, or $4,737,000, of Enron's total gas sales, respectively, for 1985 and 1986.

Connecticut Light & Power Company (70-6799)

The Connecticut Light and Power Company ("CL&P"), Selden Street, Berlin, Connecticut 06037, an electric and gas utility subsidiary of Northern Utilities, a registered holding company, has filed a post-effective amendment to its application-declaration pursuant to sections 6 and 7 of the Act.

By orders dated May 17, 1983, December 29, 1983 and June 28, 1984 (HCAR Nos. 22940, 23187 and 23351, respectively), CL&P was authorized to enter into an interest rate swap and related term-loan agreement. CL&P now proposes to replace the term-loan agreement that underlies CL&P's existing $75 million interest rate swap, for the remainder of the period July 2, 1987 to July 2, 1991.

American Electric Power Company, Inc. (70-7389)

American Electric Power Company, Inc., 1 Riverside Plaza, Columbus, Ohio 43215 ("American"), a registered holding company, Michigan Power Company, P.O. Box 13, Three Rivers, Michigan 49093 ("Michigan Power"), its public utility subsidiary, Michigan Gas Company, 1 Riverside Plaza, Columbus, Ohio 43215 ("MGC"), a presently inactive company, and Southeastern Michigan Gas Enterprises, Inc., 405 Water Street, Port Huron, Michigan 48060 ("Southeastern"), an unaffiliated exempt holding company ("collectively, Applicants-declarants"), have filed a joint application-declaration pursuant to Sections 2(a)(7), 3(a)(1), 6(a), 7, 9(a)(1) and (2), 10, 11 and 12 (c), (d) and (f) of the Act and Rules 2, 43, 44, 45, and 46 thereunder.

Applicants/declarants request authorization for a series of transactions, the ultimate effect of which is to dispose of the gas utility properties of Michigan Power to MGC, which will become a gas utility subsidiary of Southeastern, which is intended to remain exempt under section 3(a)(1) of the Act pursuant to Rule 2. Pursuant to Commission order dated July 24, 1967 (HCAR No. 15800), American acquired Michigan Power, a previously nonaffiliated company owning and operating a combination gas and electric utility business. Such acquisition was conditioned on American's divestiture of the gas utility properties of Michigan Power and the order of July 24, 1967 reserved jurisdiction over the disposition of such properties.

American and Michigan Power now propose to sell the gas utility properties of Michigan Power to MGC which, will issue to American its securities, which American will sell to Southeastern, all pursuant to a purchase agreement dated January 28, 1987 among American, Michigan Power and Southeastern ("Purchase Agreement"). The transactions proposed in the Purchase Agreement, all deemed to occur concurrently, are summarized as follows: (1) American will cause MGC to issue and sell to American its $10 million unsecured demand promissory note, payable five years from the date of issuance, and bearing interest at an annual rate of 10% per annum ("Capital Note") and 10 shares of common stock, par value $1.00 per share, of MGC ("Common Stock") in exchange for cash equal to the aggregate of (a) the Purchase Price, and (b) the Purchase Price Adjustment Amount (both as defined in the Purchase Agreement). (2) American shall cause Michigan Power to sell and MGC to purchase the Gas Assets (as defined in the Purchase Agreement) of Michigan Power for cash equal to the aggregate of (a) the Purchase Price, and (b) the Purchase Price Adjustment Amount. (3) American will sell to Southeastern the Capital Note and the Common Stock for cash equal to the aggregate of (a) the Purchase Price, and (b) the Purchase Price Adjustment Amount paid in accordance with the Purchase Agreement.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 87-13257 Filed 6-9-87; 8:45 am]

BILLING CODE 8010-01-M

SMALL BUSINESS ADMINISTRATION

[License No. 06/10-0056]

Filing of Application for Transfer of Ownership and Control; Interfirst Venture Corp.

Notice is hereby given that an application has been filed with the Small Business Administration (SBA), pursuant to § 107.601 of the Regulations governing small business investment companies (13 CFR 107.601 (1987)) for a transfer of ownership and control of Interfirst Venture Corporation, 901 Main Street, 10th Floor, Dallas, Texas 75283, a Federal Licensee under the Small Business Investment Act of 1958 (the Act), as amended (15 U.S.C. 661 *et seq.*). The proposed transfer of ownership and control of Interfirst Venture Corporation, which was licensed June 22, 1961, is subject to the prior written approval of SBA.

The transfer of ownership and control relates to a proposed marger of Interfirst Corporation with a wholly-owned subsidiary of RepublicBank Corporation. This merger will result in a merger of Interfirst Bank Dallas, parent company of Interfirst Venture Corporation, into RepublicBank Dallas, and Interfirst Venture Corporation will become a wholly-owned indirect subsidiary of RepublicBank Corporation. No person or other corporation owns 10 percent or more of RepublicBank Corporation's voting securities.

There is no change of management of Interfirst Venture Corporation contemplated in connection with the proposed change of ownership and control.

Matters involved in SBA's consideration of the application include the general business reputation and character of the managment, and the probability of successful operations of the company under their managment, including profitability and financial soundness, in accordance with the Act and Regulations.

Notice is hereby given that any person may, not later than 30 days from the date of publication of this Notice, submit written comments on the proposed transfer of ownership and control to the Deputy Associate Administrator for Investment, Small Business

Administration, 1441 "L" Street NW., Washington, DC 20416. A copy of this Notice will be published in a newspaper of general circulation in Dallas, Texas.

(Catalog of Federal Domestic Assistance Program No. 59.011, Small Business Investment Companies)

Robert G. Lineberry,

Deputy Associate Administrator for Investment.

Dated: June 1, 1987.

[FR Doc. 87-13185 Filed 6-9-87; 8:45 am]

BILLING CODE 8025-01-M

DEPARTMENT OF TRANSPORTATION

Federal High Administration

Environmental Impact Statement; Lake County; IN

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of Intent.

SUMMARY: The FHWA is issuing this notice to advise the public that an environmental impact statement will be prepared for a proposed highway project in Lake County, Indiana. A project is proposed to widen U.S. 30 generally on existing alignment from the Illinois-Indiana State Line to U.S. 41. As proposed, a 5-lane roadway cross-section bordered by curbs and gutters will be provided within a proposed right of way typically 100' wide.

FOR FURTHER INFORMATION CONTACT: Mr. James E. Threlkeld, District Engineer, Federal Highway Administration, Federal Office Building, 575 North Pennsylvania Street, Room 254, Indianapolis, Indiana 46204, Telephone: (317) 269-7494.

SUPPLEMENTARY INFORMATION: The FHWA in cooperation with the Indiana Department of Highways (IDOH) will prepare an environmental impact statement for a proposed 2.94 mile project on U.S. 30 extending from the Illinois-Indiana State Line to U.S. 41, passing through the Towns of Dyer and Schererville. Existing 3-4 lane U.S. 30 is proposed to be widened to provide two, 12' lanes in each direction separated by a continuous left turn lane 16' wide and bordered by curbs and gutters and sidewalks, all contained in a right of way typically 100' wide. New twin bridges are proposed to be built over Plum Creek and the existing twin bridges over Dyer Ditch are proposed to be widened.

Major intersections at Hart Street, Sheffield Avenue (extended), Calumet Avenue (extended), St. John Road and U.S. 41 are proposed to be up-graded to increase capacity and safety. This project is proposed to address capacity problems and restricted Levels of Service on U.S. 30, particularly at the Hart Street and U.S. 41 intersections. Current traffic volumes of 26,000 to 34,700 vehicles per day are projected to increase to 36,000 to 48,000 vehicles per day by the year 2006.

In addition to the proposed 5-lane cross section improvement throughout the total project termini, two alternate improvement options are to be considered. The first alternate proposes only a series of isolated spot improvements at the major intersections and the stream crossings. The second alternate proposes to make no improvements to U.S. 30 within the project limits.

To ensure that the full range of issues related to this proposed action are addressed and that all significant issues are identified, those agencies, groups or individuals affected by or interested in this proposed action are invited to participate by sending their written comments to the FHWA. No formal scoping meeting will be conducted. Early coordination contacts have been initiated with 26 Federal, State and local agencies having either jurisdiction or special expertise.

(Catalog of Federal Domestic Assistance Program No. 20.205, [Highway Research, Planning and Construction], the provisions of Executive Order 12372 regarding State and local inter-governmental review of Federal and Federally-assisted programs and projects apply to this program.)

Issued on: June 2, 1987.

Arthur A. Fendrick,

Division Administrator.

[FR Doc. 87-13149 Filed 6-9-87; 8:45 am]

BILLING CODE 4910-22-M

Urban Mass Transportation Administration

Solicitation of Expressions of Interest and Capabilities in Providing Transit Bus Maintenance Services

AGENCY: Urban Mass Transportation Administration, DOT.

ACTION: Notice.

SUMMARY: The Urban Mass Transportation Administration (UMTA) announces that it is seeking expressions of interest and capabilities from firms interested in providing bus maintenance services to transit agencies under a competitive procurement process.

DATE: Responses are due within 45 days of this notice.

ADDRESS: DOT/UMTA 400 7th Street, SW., Washington, DC 20590 URT-31, Room 6100.

FOR FURTHER INFORMATION CONTACT: Mr. Philip G. Hughes, (202) 366-4984, UMTA Headquarters.

Background

UMTA has been promoting the use of competitive practices in the provision of mass transportation services to ensure that Federal assistance is efficiently and effectively utilized. The results to date have produced significant cost reductions. UMTA desires to extend and promote competitive practices in the provision of bus transit maintenance services. As a means of accomplishing this, UMTA desires to identify firms that are interested in providing a range of bus maintenance services to transit agencies. The basic types of maintenance arrangements being considered are:

- Contractor to provide complete turnkey operation which would include facility, equipment, labor and management capable of performing complete servicing and maintenance of a fleet of transit buses.
- Contractor to provide labor and management which would service and maintain a fleet of transit buses in a facility provided and equipped by the transit agency.

Interested firms should provide the following information: Name and address of firm, name and telephone number of contact person, type of services described above that firm is able to provide, geographic area or areas where firm could provide these services, and any pertinent prior experience. Responses should be as brief as possible.

Depending upon the nature of responses received, listings of firms by geographic area of interest, e.g. national or regional, will be assembled, UMTA then expects to make these listings available to local transit agencies considering contracting with private firms for transit bus maintenance.

Dissemination of these list(s) by UMTA will not constitute an endorsement of any firm, or representation as to the capabilities of a firm. The information is provided solely to expand the awareness of transit agencies to possible contract sources.

Issued: May 30, 1987.

Ralph L. Stanley,

Urban Mass Transportation Administration.

[FR Doc. 87-13147 Filed 6-9-87; 8:45 am]

BILLING CODE 4910-57-M

Solicitation of Innovative Concepts for the Use of Competition To Obtain Transit Vehicle Maintenance Services

AGENCY: Urban Mass Transportation Administration, DOT.

ACTION: Notice.

SUMMARY: The Urban Mass Transportation Administration (UMTA) announces that it is seeking innovative concepts for the competitive procurement of vehicle manintenance services by transit agencies.

DATE: Concept submittals are due July 10, 1987.

ADDRESS: DOT/UMTA, 400 7th Street, SW., Washington, DC 20590, URT-31, Room 6100.

FOR FURTHER INFORMATION CONTACT: Mr. Philip G. Hughes, (202) 366-4984, UMTA Headquarters.

Background

UMTA has been promoting the use of competitive practices in the provision of mass transportation services to ensure that Federal assistance is efficiently and effectively spent. The results to date have produced significant cost reductions. UMTA desires to extend and test competitive practices in the provision of transit maintenance services.

As a means of accomplishing this, UMTA desires to fund a series of demonstrations that will involve competition by public and private entities for the provision of the maintenance of a transit agency's full size bus fleet. UMTA wants to encourage interested transit agencies to develop innovative approaches that would lead to competition for maintenance services for all or a significant portion of its total fleet.

UMTA Section 6 funding would be available for the development and monitoring of the demonstration. In addition, UMTA's "Capital Cost of Contracting" Circular, UMTA C7010.1, December 5, 1986, describes a process which can be applied to help cover the capital costs of contracting maintenance. This policy allows grantees to use their Federal capital assistance (Sections 3, 9, 16(b) (2), and 18) to pay for capital depreciation expenses that are included in a contract price of a capital item, as well as the leasing of facilities and equipment when the service is competitively procured. Grant recipients must be able to collect comparative cost data for an analysis of both in-house and contracted maintenance and be agreeable to the publication of an analysis of the data.

Interested transit agencies should submit a letter to UMTA which includes a narrative description of the proposed concept, estimated Federal assistance required for a demonstration, expected duration of the demonstration and other pertinent information that will enable UMTA to assess the potential viability of the proposed demonstration. UMTA will select one or more of the concepts and then request that a formal grant application be submitted.

Issued: May 29, 1987.

Ralph L. Stanley,

Urban Mass Transportation Administrator.

[FR Doc. 87-13146 Filed 6-9-87; 8:45 am]

BILLING CODE 4910-57-M

DEPARTMENT OF THE TREASURY

Public Information Collection Requirements Submitted to OMB for Review

Date: June 5, 1987.

The Department of Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1980, Pub. L. 96-511. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 2224, 15th and Pennsylvania Avenue, NW., Washington, DC 20220.

Bureau of the Public Debt

OMB Number: 1535-0042
Form Number: 2216
Type of Review: Reinstatement
Title: Application for Preferred Creditor for Disposition with Administration Where Deceased Owner's Estate Includes Registered Securities
Description: Form lessens paperwork otherwise necessary to establish preferred creditor of a person, now deceased, whose estate is not being administered by a court appointed representative. Used by person or organization taking care of funeral expenses and/or unpaid bills of decedent.
Respondents: Individuals, Businesses
Estimated Burden: 500 hours

OMB Number: 1535-0049
Form Number: 1006
Type of Review: Reinstatement
Title: Specific Power of Substitution Under Power of Attorney Granted to an Individual to Dispose of Registered Securities
Description: Upon the request of the owner of Treasury securities, he/she may use this form to appoint a successor attorney-in-fact to replace a previous attorney-in-fact. The form greatly lessens the legal paperwork necessary to delegate this authority to appoint a caretaker for the securities.
Respondents: Individuals, Businesses
Estimated Burden: 45 hours

OMB Number: 1535-0050
Form Number: 1003
Type of Review: Reinstatement
Title: Power of Attorney by a Corporation or Unincorporated Association Authorizing Disposition of Registered Transfer Securities
Description: Form is used as the request by an officer of a corporation or an official of an unincorporated association. The officer or official may use the form to lessen the paperwork necessary to appoint an attorney-in-fact to act as a caretaker, who may legally dispose of the corporation's Treasury securities.
Respondents: State or local governments, Businesses, Non-profit institutions
Estimated Burden: 165 hours

OMB Number: 1535-0051
Form Number: 1001
Type of Review: Reinstatement
Title: Power of Attorney for Individuals Authorizing Disposition of Registered Transferable Securities
Description: Form is used as a request by the owner of a Treasury security. He/she may use the form to lessen the paperwork legally necessary to appoint an attorney-in-fact to handle any transaction involving the registered owner's or co-owner's Treasury securities.
Respondents: Individuals
Estimated Burden: 180 hours

OMB Number: 1535-0053
Form Number: 1014
Type of Review: Reinstatement
Title: Certification of Incumbency of Corporate or Organizational Officers
Description: The form lessens paperwork otherwise necessary to establish the incumbency of an officer of a corporation or organization. Without the evidence, an unauthorized officer could act for his company or organization. Small businesses would only employ the use of this form if incorporated.
Respondents: State or local governments, Businesses, Federal agencies or employees
Estimated Burden: 160 hours

OMB Number: 1535-0055
Form Number: 1050

Type of Review: Reinstatement
Title: Creditor's Consent to Disposition of United States Securities and Related Checks Without Administration of Deceased Owner's Estate
Description: Form is used to obtain a creditor's consent to dispose of savings bonds and other securities in settlement of a deceased owner's estate without administration.
Respondents: Individuals
Estimated Burden: 350 hours

OMB Number: 1535–0056
Form Number: 1461
Type of Review: Reinstatement
Title: Application for Recognition of a Voluntary Guardian of the Owner of Registered Securities and for Disposition of the Securities
Description: At the applicant's request, the form is provided and lessens the paperwork necessary to establish the applicant as the voluntary guardian for an incompetent, when Treasury securities are sought as an investment for an incompetent.
Respondents: Individuals
Estimated Burden: 37 hours

OMB Number: 1535–0062
Form Number: 2966
Type of Review: Reinstatement
Title: Special Bond of Indemnity to the United States of America
Description: The form is used by the purchaser of savings bonds in a chain letter scheme to request refund of the purchase price of the bonds. Form is used to indemnify the Bureau of the Public Debt in such cases.
Respondents: Individuals
Estimated Burden: 1,100 hours

OMB Number: 1535–0063
Form Number: 4239
Type of Review: Reinstatement
Title: Request by Owner or Person Entitled for Payment or Reissue of U.S. Savings Bonds/Notes Deposited in Safekeeping When Original Custody Receipts are not Available
Description: Form is used as a request by owner or person entitled for return payment or reissue of United States Savings Bonds/Notes in Safekeeping when original custody receipts are not available.
Respondents: Individuals
Estimated Burden: 150 hours

OMB Number: 1535–0064
Form Number: PD 1980, PD 2490, PD 3500
Type of Review: Reinstatement
Title: Description of United States Savings Bonds Series HH/H, Description of United States Savings Bonds/Notes, Continuation Sheet for Listing Securities
Description: This form is used by an owner of United States Bonds to describe the owner's security holdings who apply for some type of relief or service by the Bureau of the Public Debt.
Respondents: Individuals
Estimated Burden: 5,100 hours

OMB Number: 1535–00
Clearance Officer: Peter Laugesen (202) 376–3902, Bureau of the Public Debt Room 445, 999 E. Street, NW., Washington, DC 20226
OMB Reviewer: Milo Sunderhauf, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, DC 20503

Dale A. Morgan,

Departmental Reports Management Officer.

[FR Doc. 87–13216 Filed 6–9–87; 8:45 am]

BILLING CODE 4810–25–M

Public Information Collection Requirements Submitted to OMB for Review

Date: June 5, 1987.

The Department of Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1980, Pub. L. 96–511. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 2224, 15th and Pennsylvania Avenue, NW., Washington, DC 20220.

Bureau of Alcohol, Tobacco and Firearms

OMB Number: 1512–0475
Form Numbers: ATF Form 4473, Part I and Part II, and ATF REC 5300/1 and 7570/2
Type of Review: Extension
Title: Record Retention Period and Certain Firearms Records
Description: The retention period for firearms records required to be kept by firearms licensees was reduced by regulations published on June 28, 1985. The period of retention is considered minimal in order to properly serve law enforcement entities.
Respondents: Businesses
Estimated Burden: 1 hour

OMB Number: 1512–0001
Form Numbers: ATF F 1600.1 and ATF F 1600.8
Type of Review: Extension
Title: Requistion for Forms or Publications, Requisition for Firearms/Explosives Forms
Description: These forms are used by the general public to request or order forms or publications from the Bureau's Distribution Center. The forms notify the Bureau of the quantity required by the respondent and provide a guide as to annual usage of forms and publications by the general public.
Respondents: Individuals, Businesses
Estimated Burden: 1,725 hours
Clearance Officer: Robert Masarsky (202) 566–7077, Bureau of Alcohol, Tobacco and Firearms, Room 7011, 1200 Pennsylvania Avenue, NW., Washington, DC 20226
OMB Reviewer: Milo Sunderhauf (202) 395–6880, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, DC 20503

Internal Revenue Service

OMB Number: 1545–0863
Form Number: None
Type of Review: Extension
Title: Product Liability Losses and Accumulations for Product Liability Losses
Description: Generally, a taxpayer who sustains a product liability loss must carry that back 10 years. Howerver, a taxpayer may elect to have such loss treated as a regular net operating loss under section 172. If desired, such election is made by attaching a statement to the tax return. This statement will enable the IRS to monitor compliance with the statutory requirements.
Respondents: Businesses
Estimated Burden: 2,500 hours
Clearance Officer: Garrick Shear (202) 566–6150, Internal Revenue Service, Room 5571, 1111 Constitution Avenue, NW., Washington, DC 20224
OMB Reviewer: Milo Sunderhauf, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, DC 20503

U.S. Customs Service

OMB Number: 1515–0041
Form Number: 6059–B
Type of Review: Extension
Title: U.S. Customs Declaration
Description: The Customs Form 6059–B facilitates the clearance of persons and their goods upon arrival in the territory of the U.S. by requiring basic information necessary to determine Customs exception status and if any duties or taxes are due. The form is also used for the enforcement of Customs and other federal agencies laws and regulations.
Respondents: Individuals
Estimated Burden: 1,000,000 hours

Clearance Officer: B. J. Simpson (202) 566–7529, U.S. Customs Service, Room 6426, 1301 Constitution Avenue, NW., Washington, DC 20229
OMB Reviewer: Milo Sunderhauf (202) 395–6880, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, DC 20503

Dale A. Morgan,

Departmental Reports, Management Officer.

[FR Doc. 87–13217 Filed 6–9–87; 8:45 am]

BILLING CODE 4810–25–M

Sunshine Act Meetings

Federal Register
Vol. 52, No. 111
Wednesday, June 10, 1987

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

FEDERAL ENERGY REGULATORY COMMISSION

June 5, 1987.

The following notice of meeting is published pursuant to section 3(a) of the Government in the Sunshine Act (Pub. L. No. 94-409), 5 U.S.C. 552B:

TIME AND DATE: June 12, 1987, 8:30 a.m.

PLACE: 825 North Capitol Street, NE., Room 9306, Washington, DC 20426.

STATUS: Open.

MATTERS TO BE CONSIDERED: Agenda.

* Note.—Items listed on the agenda may be deleted without further notice.

CONTACT PERSON FOR MORE INFORMATION: Kenneth F. Plumb, Secretary, Telephone (202) 357-8400.

This is a list of matters to be considered by the Commission. It does not include a listing of all papers relevant to the items on the agenda; however, all public documents may be examined in the Public Reference Room.

Consent Power Agenda, 858th Meeting—June 12, 1987, Regular Meeting (8:30 a.m.)

CAP-1.
Project No. 3239-004, Puget Sound Power & Light Company and McMaster and Schroder
CAP-2.
Project No. 6986-004, Tranquility Irrigation District
CAP-3.
Project No. 3795-003, Thermalito Irrigation District and Table Mountain Irrigation District
CAP-4.
Project No. 9432-002, Town of Easthampton
CAP-5.
Project No. 137-002, Pacific Gas and Electric Company
CAP-6.
Project No. 3083-028, KAMO Electric Cooperative, Inc. and Oklahoma Municipal Power Authority
CAP-7.
Project No. 7327-004, Greenfields Irrigation District and Turnbull Partners, Ltd.
CAP-8.
Projects Nos. 344-002 and 003, Southern California Edison Company
CAP-9.
Docket No. ER87-390-000, Connecticut Yankee Atomic Power Company
CAP-10.
Docket No. EL87-23-002, Connecticut Yankee Atomic Power Company
CAP-11.
Docket No. ER87-333-000, Dayton Power & Light Company and Ohio Edison Company
CAP-12.
Docket No. ER87-396-000, Golden Spread Electric Cooperative, Inc.
CAP-13.
Docket No. ER87-387-000, Pennsylvania Power & Light Company
CAP-14.
Docket Nos. ER87-280-000, ER87-281-000, and ER87-355-000, Appalachian Power Company, Indiana & Michigan Electric Company, Kentucky Power Company, Ohio Power Company and Wheeling Electric Company
CAP-15.
Docket No. ER87-386-000, New England Hydro-Transmission Corporation, New England Hydro-Transmission Electric Company, New England Power Company, Boston Edison Company and Public Service Company of New Hampshire
CAP-16.
Docket Nos. EF87-2011-016, -017, -018, and -019, United States Department of Energy—Bonneville Power Administration
CAP-17.
Docket No. ER87-107-003, Idaho Power Company and Utah Power & Light Company
Docket No. EL87-8-001, Pacific Power & Light Company
Docket No. ER86-570-003, Idaho Power Company
CAP-18.
Docket No. QF86-512-001, Nelson Industrial Steam Company
CAP-19.
Docket No. ER87-3444-005, Maine Yankee Atomic Power Company
Docket No. EL87-12-000, Connecticut Division of Consumer Counsel. v. Connecticut Yankee Atomic Company, Yankee Atomic Electric Company, Maine Yankee Atomic Power Company, and Vermont Yankee Nuclear Power Corporation
CAP-20.
Docket Nos. ER86-405-002, ER86-468-002, ER86-517-002, ER87-183-001 and EL87-4-000, Boston Edison Company
CAP-21.
Docket No. ER87-3-001, Boston Edison Company
CAP-22.
Docket No. ER87-34-001, Metropolitan Edison Company
CAP-23.
Docket No. EL86-22-001, Airco, Inc. and SKW Alloys, Inc.
CAP-24.
Docket No. IR-000-484, Seminole Electric Cooperative, Inc., Central Florida Electric Cooperative, Inc., Glades Electric Cooperative, Inc., Lee County Electric Cooperative, Inc., Okefenoke Rural Electric Membership Corporation, Peace River Electric Cooperative, Inc., Sumter Electric Cooperative, Inc., Suwannee Valley Electric Cooperative, Inc., Talquin Electric Cooperative, Inc., and Tri-County Electric Cooperative, Inc.
Docket No. IR-000-320, Clay Electric Cooperative, Inc.
Docket No. IR-000-877, Withlacoohee River Electric Cooperative, Inc.
CAP-25.
Docket No. EL86-18-000, Consolidated Edison Company of New York, Inc.
CAP-26.
Docket No. QF86-896-001, Clarion Power Company
CAP-27.
Project No. 710-000 Wisconsin Power & Light Company

Consent Miscellaneous Agenda

CAM-1.
Omitted
CAM-2.
Docket No. FA86-19-000, Systems Energy Resources, Inc.
CAM-3.
Docket No. GP85-19-000, Champlin Petroleum Company, Carthage Gas Unit Well Nos. 11-4, 12-2, 13-3, 14-2, and 21-2
CAM-4.
Docket No. RO86-32-000, Texaco, Inc.

Consent Gas Agenda

CAG-1.
Omitted
CAG-2.
Docket No. TA87-3-43-003, Williams Natural Gas Company
CAG-3.
Docket No. RP86-110-005, Texas Eastern Transmission Corporation
Docket Nos. RP86-93-002 and RP86-93-003, United Gas Pipe Line Company
Docket No. RP85-175-007, Transwestern Pipeline Company
Docket No. CP86-585-002, Panhandle Eastern Pipe Line Company
Docket No. CP86-586-001, Trunkline Gas Company
Docket No. CP86-521-001, Texas Gas Transmission Company
Docket No. CP86-578-001, Northwest Pipeline Corporation
Docket Nos. RP86-105-002 and RP86-105-008, ANR Pipeline Company
Docket No. CP86-589-001, Colorado Interstate Gas Company
Docket No. RP85-169-007, Consolidated Gas Transmission Company
Docket No. RP86-109-003, Kentucky West Virginia Gas Company
Docket Nos. RP86-97-004, RP86-97-006, RP86-97-007 and RP87-72-000, Natural Gas Pipeline Company of America
Docket Nos. RP85-206-009 and RP85-206-028, Northern Natural Gas Company
CAG-4.

Omitted
CAG–5.
Docket Nos. RP88–150–001 and RP88–150–002, El Paso Natural Gas Company
CAG–6.
Docket Nos. RP87–39–001 and RP87–33–004, Williams Natural Gas Company
CAG–7.
Docket No. TA87–4–21–004, Columbia Gas Transmission Corporation
CAG–8.
Docket No. TA87–1–53–000, KN Energy, Inc.
CAG–9.
Docket Nos. TA84–2–49–000 and TA85–1–49–000, Williston Basin Interstate Pipeline Company
CAG–10.
Docket No. TA87–1–11–002, United Gas Pipe Line Company
CAG–11.
Docket No. ST86–2041–000, Supenn Pipeline
CAG–12.
Docket No. ST85–1608–001, Producer's Gas Company
CAG–13
Docket Nos. CI86–307–002 and CI86–688–002, Sea Robin Pipeline Company
CAG–14
Docket Nos. CI86–686–000, CI86–687–000, CI86–701–000, and CI86–702–000, Franks Petroleum *et al.*
CAG–15
Docket Nos. CI86–595–000 and CI86–597–000, Sea Robin Pipeline Company
CAG–16.
Docket Nos. CI87–184–000 and CI87–185–000, Mid-Louisiana Gas Company
CAG–17.
Docket No. CI86–180–000, Holden Energy Corporation
CAG–18.
Docket Nos. CP86–747–003, CP86–265–002, CP86–406–002 and CP87–125–002, Transcontinental Gas Pipe Line Corporation
CAG–19.
Docket No. CP86–693–001, Washington Gas Light Company
CAG–20.
Docket Nos. CP86–86–001, Northern States Power Company
CAG–21.
Docket Nos. CP86–277–005, *et al.*, Southern Natural Gas Company
CAG–22.
Docket No. CP86–571, Tennessee Gas Pipeline Company, a Division of Tenneco Inc.
CAG–23.
Docket Nos. CP86–733–000, Equitable Gas Company
CAG–24.
Docket Nos. CP87–150–000 and CP87–197–000, United Gas Pipe Line Company
CAG–25.
Omitted
CAG–26.
Docket No. CP86–142–000, Natural Gas Pipeline Company of America
CAG–27.
Docket No. CP84–654–018, Algonquin Gas Transmission Company
CAG–28.
Docket Nos. CP87–171–000, CP87–172–000, RP87–33–000 and RP87–39–000, Williams Gas Company
CAG–29.
Docket No. CI69–491–001, Amoco Production Company
CAG–30.
Docket No. CI87–381–000, National Cooperative Refinery Association

I. Licensed Project Matters

P–1.
Omitted

II. Electric Rate Matters

ER–1.
Docket Nos. ER82–774–000, ER83–209–000 and ER83–227–000, Tapoco, Inc.
Docket Nos. ER82–829–000 and ER83–219–000, Nantahala Power and Light Company
Docket No. EL83–6–000, Lacey H. Thornburg, Attoney General of the State of North Carolina v. Aluminum Company of America, Tapoco, Inc., and Nantahala Power and Light Company
Docket No. EL84–29–000, Town of Highlands, North Carolina, *et al.* v. Nantahala Power and light Tapoco, Inc., *et al.*, Docket No. ER82–774–000, *et al.* Opinion on initial decision establishing just and reasonable rates.
ER–2.
Docket No. EL87–10–000, Central Vermont Public Service Corporation. Order concerning jurisdictional status of a proposed corporate reorganization.
ER–3.
Docket No. IR–000–111, The City of Longmont, Colorado
Docket No. IR–000–772, The City of Loveland, Colorado
Docket No. IR–000–151, The Town of Estes Park, Colorado
Docket No. IR–000–433, The City of Fort Collins, Colorado
Order on petition for waiver of Part 292 of Commission's regulations.

Miscellaneous Agenda

M–1.
Docket No. RM86–6–000, Construction Work in Progress—Anticompetitive Implications. Final Rule.
M–2.
Reserved
M–3.
Reserved
M–5.
M–4. Docket No. RM87–22–000, Deregulation and Other Pricing Changes on July 1, 1987, Under the Natural Gas Policy
M–5.
Docket No. RM87–17–000, Natural Gas Data Collection System. Notice of Proposed Rulemaking.

I. Pipeline Rate Matter

RP–1(A).
Docket No. RP86–14–000 and RP86–108–000 through –016, Columbia Gulf Transmission Company
Docket Nos. RP86–15–000 and RP86–112–000 through –017, Columbia Gas Transmission Corporation.
Order concerning Order No. 436 settlements and related rehearing requests.
RP–1(B).
Omitted
RP–2.
Docket Nos. RP86–106–000 and RP86–106–001, Arkla Energy Resources, a division of Arkla, Inc.
Order concerning Order No. 436 settlement.
RP–3.
Docket No. RP87–34–000, Northwest Alaskan Pipeline Company. Order concerning take-or-pay settlement agreement and transporation.
RP–4.
Docket No. CP79–396–004, Northern Natural Gas Company, a Division of Enron Corporation
Docket No. CP79–400–002, United Gas Pipe Line Company. Request for section 7(c) authorization for exchange arrangement and balancing receipt points (related to RP–3).
RP–5.
Docket No. GP83–35–000, Southern Natural Gas Company. Declaratory order concerning NGPA Title I.

II. Producer Matters

CI–1.
Reserved

III. Pipeline Certificate Matters

CP–1.
Docket Nos. CP83–75–000, CP83–75–001 and CP83–75–002, Consolidated System LNG Company
Docket Nos. CP80–33–001 and CP80–33–002, Columbia LNG Corporation. Settlement regarding section 7(b) and 7(c) authority to transfer, acquire and abandon ownership interests in and operating responsibilities for Cove Point liquefied natural gas facilities.

Kenneth F. Plumb,

Secretary.

[FR Doc. 87–13309 Filed 6–8–87; 10:56 am]

BILLING CODE 6717–01–M

FEDERAL RESERVE SYSTEM

TIME AND DATE: 11:00 a.m., Monday, June 15, 1987.

PLACE: Marriner S. Eccles, Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, DC 20551.

STATUS: Closed

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.
2. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452–3204. You may call (202) 452–3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Dated: June 5, 1987.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 87-13277 Filed 6-8-87; 10:10 am]

BILLING CODE 6210-01-M

TENNESSEE VALLEY AUTHORITY

"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT: To be published June 8, 1987.

PREVIOUSLY ANNOUNCED TIME AND DATE OF MEETING: 10 a.m. (e.d.t.) Wednesday, June 10, 1987.

PREVIOUSLY ANNOUNCED PLACE OF MEETING: TVA West Tower Auditorium, 400 West Summit Hill Drive, Knoxville, Tennessee.

STATUS: Open.

ADDITIONAL MATTER:

The following item is added to the previously announced agenda:

E—Real Property Transactions

2. Sale at public auction of the Phipps Bend Nuclear Plant site located in Hawkins County, Tennessee, containing approximately 1,200 acres, under section 31 of the TVA Act.

CONTACT PERSON FOR MORE INFORMATION: Alan Carmichael, Director of Information, or a member of his staff can respond to requests for information about this meeting. Call 615-632-8000 or 632-6000 (News Desk), Knoxville, Tennessee. Information is also available at TVA's Washington Office, 202-245-0101.

SUPPLEMENTARY INFORMATION:

TVA Board Action

The TVA Board of Directors has found, the public interest not requiring otherwise, that TVA business requires the subject matter of this meeting be changed to include the additonal item shown above and that no earlier announcement of this change was possible.

The members of the TVA Board voted to approve the above findings and their approvals are recorded below:

Dated: June 5, 1987.

Approved.

C.H. Dean, Jr.,

Director and Chairman.

John B. Waters,

Director.

[FR Doc. 87-13266 Filed 6-8-87; 9:08 am]

BILLING CODE 8120-01-M

Corrections

Federal Register
Vol. 52, No. 111
Wednesday, June 10, 1987

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents and volumes of the Code of Federal Regulations. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF AGRICULTURE

Commodity Credit Corporation

Price Support Grade Loan Rates for the 1987-Crop Tobacco Price Support Loan Program; Request for Comments

Correction

In notice document 87-12311 beginning on page 20126 in the issue of Friday, May 29, 1987, make the following correction:

On page 20126, in the first column, in the **DATES** paragraph, remove "(insert 30 days after publication in the FR)" and insert "June 29, 1987".

BILLING CODE 1505-01-D

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

7 CFR Part 226

Child Care Food Program; Documentation and Verification of Eligibility

Correction

In proposed rule document 87-11686 beginning on page 19354 in the issue of Friday, May 22, 1987, make the following corrections:

1. On page 19354, in the first column, in the **SUMMARY**, in the 25th line, "and" should read "the".

2. On the same page, in the second column, in **SUPPLEMENTARY INFORMATION**, in the first paragraph, in the 10th line, "will have" should read "will not have"; in the second paragraph, in the last line, "entitles" should read "entities".

3. On the same page, in the third column, in the first line, "Pub. L. 99-551" should read "Pub. L. 99-591".

4. On page 19355, in the first column, in the third line, "of" should read "or".

5. On the same page, in the first column, in the 36th line, "income" should read "Income".

6. On the same page, in the third column, in the sixth line, "*Applications*" should read "*Application*".

7. On the same page, in the third column, in the first complete paragraph, in the eighth line, "DDFP" should read "CCFP".

8. On the same page, in the third column, in the fourth complete paragraph, in the fifth line, "will not" should read "will now".

9. On page 19356, in the second column, in the sixth line, "§ 226.23(e)(iii)" should read "§ 226.23(e)(1)(iii)".

10. On the same page, in the second column, in the seventh line from the bottom, "Written" was misspelled.

11. On the same page, in the third column, in the "Authority", in the last line, "171779" should read "1779".

§ 226.2 [Corrected]

12. On page 19357, in § 226.2, in the first column, in the definition for "Verification" in the 16th line, "income" should read "information".

13. On the same page, in the second column, in amendatory instruction 7, the second paragraph "a." should read "b.".

14. On the same page, in the second and third columns, change "§ 266." to "§ 226." wherever it appears.

§ 226.17 [Corrected]

15. On the same page, in the second column, in the second amendatory instruction 7, in the first line, "(b)(17)" should read "(b)(7)".

§ 226.19 [Corrected]

16. On the same page, in the third column, in amendatory instruction 9, in the first line, the paragraph designation should read "(b)(9)(i)".

§ 226.23 [Corrected]

17. On the same page, in the third column, in amendatory instruction 10d, in the third line, "(e)(1)(ii)" should read "(e)(1)(iii)".

§ 226.23 [Corrected]

18. On page 19358, in § 226.23(e)(1)(iii)(A), in the second column, in the first line, "stamps" should read "stamp".

19. On the same page, in § 226.23(e)(1)(iii)(B), in the third line, beginning with "In", the two sentences should start a new flush paragraph; and in the seventh line, "stamps" should read "stamp".

20. On the same page, before § 226.23(h)(2), insert a line of five asterisks.

21. On the same page, in § 226.23(h)(2), in the second column, in the second line, "(1)" should read "(i)".

22. On page 19359, in the first column, in § 226.23(h)(2)(iv)(C), in the seventh line, "agencies" was misspelled.

BILLING CODE 1505-01-D

DEPARTMENT OF AGRICULTURE

Forest Service

Transfer of Administrative Jurisdiction; Laurel River Lake, KY

Correction

In notice document 87-11802 beginning on page 19367 in the issue of Friday, May 22, 1987, make the following corrections:

1. On page 19368, in the first column, the signature line should read "**John O. Marsh, Jr.**" and in the next line remove "*Jr.,*".

2. On the same page, in the first column, in **EXHIBIT A**, in Segment 6, "610" should read "601"; in Segment 9, in the third line, "292" should read "929"; and in the last line of the column, insert "133M" between "132M," and "250M-1".

BILLING CODE 1505-01-D

COMMITTEE FOR PURCHASE FROM THE BLIND AND OTHER SEVERELY HANDICAPPED

Procurement List 1987; Proposed Addition and Deletions

Correction

In notice document 87-11755 appearing on page 19376 in the issue of Friday, May 22, 1987, make the following corrections:

1. On page 19376, in the third column, in the sixth line, "8067" should read "7967".

2. On the same page, in the third column, in the 24th line, "Operation" was misspelled.

BILLING CODE 1505-01-D

ENVIRONMENTAL PROTECTION AGENCY

[OPP-150002; FRL-3182-6]

Procedures for Submission of Claims for Indemnification and Disposal of 2,4,5-T and Silvex Pesticide Products

Correction

In notice document 87-7743 beginning on page 11319 in the issue of Wednesday, April 8, 1987, make the following corrections:

1. On page 11320, in the first column, in the **SUPPLEMENTARY INFORMATION**, in the second paragraph, in the fourth line, insert "effects" after "adverse".

2. On the same page, in the third column, in the first complete paragraph, in the sixth line, "October 28, 1983" should read "October 18, 1983".

3. On page 11322, in the first column, the first line was omitted and should read "Bonide Chemical Co., Inc.:".

4. On page 11323, in the second column, in the first line, "Lott's" should read "Loft's"; and in the same column, under "Agway, Inc.", in the second entry, in the first line, "12-" should read "21-".

5. On page 11324, in the third column, under "Thompson-Hayward Chemical Company", in the second entry, in the first line, "Depester" should read "De-Pester".

6. On page 11325, in the first column, in the third line from the bottom, "Osford" should read "Oxford"; and on the same page, in the second column, in the entry under "Dymon, Inc.:", in the first line, "0116940-00041" should read "011694-00041".

7. On page 11326, in the second column, in the fourth line, "4 LB" should read "4LB"; in the same column, under "Stauffer Chemical Company", in the sixth entry, in the second line, "66E" should read "66-E"; and also in the same column, under "Monsanto Company", in the fourth entry, "2,4,-D,4,5-T" should read "2,4,-D-2,4,5-T".

8. On page 11327, in the first column, under "Farmer's Union Central Exchange, Inc.", in the first entry, in the first line, insert "245" after "Co-op"; in the second column, in the ninth line, "Detteback" should read "Dettelbach"; and in the third column, under "Southern Mill Creek Products", in the second entry, the second line should read "D & T".

9. On page 11329, in the first column, in the entry for "Morgro Chemical & Energy Corp.", in the first line, "042057-0049" should read "042057-00049".

10. On page 11332, in the third column, in the fourth line, "Dryer" should read "Dyer".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[ES-940-07-4520-13; ES-037368, Group 17]

Filing of Plats of Dependent Resurvey, Subdivisions of Sections and Survey of Rend lake Acquisition Boundary; Illinois

Correction

In notice document 87-11966 appearing on page 19780 in the issue of Wednesday, May 27, 1987, make the following correction:

In the second column, in the first paragraph, in the eighth line, insert "29" between "28," and "30".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

National Park Service

36 CFR Part 7

Blue Ridge Parkway, Virginia and North Carolina; Commercial Hauling and Commercial Vehicle Regulations

Correction

In rule document 87-12360 beginning on page 20387 in the issue of Monday, June 1, 1987, make the following correction:

On page 20388, in the first column, the date line should read "Dated: May 21, 1987."

BILLING CODE 1505-01-D

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 87-ACE-1]

Proposed Alteration of VOR Federal Airways; Missouri

Correction

In a correction to proposed rule document 87-11435 appearing on page 20825 in the issue of Wednesday, June 3, 1987, make the following correction:

In the third column, in the last line of text, "T" should read "M" in both places.

BILLING CODE 1505-01-D

Federal Register

Wednesday
June 10, 1987

Part II

Department of Transportation

Office of the Secretary

14 CFR Parts 234 and 255

Airline Service Quality Performance: Notice of Proposed Rulemaking

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

14 CFR Parts 234 and 255

[Docket Nos. 44730, 44827 and 44866] (Notice 87-11)

Airline Service Quality Performance

AGENCY: Office of the Secretary, DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Department solicits comments upon a number of rulemaking alternatives that would address current airline service and disclosure issues. These same issues also have been the subject of recent rulemaking petitions filed by the Airline Consumer Action Project (ACAP), Continental Airlines, Inc., and American Airlines, Inc., and responses to the petitions filed with the Department by United Air Lines, Inc., and Delta Airlines, Inc. and Trans World Airlines, Inc. (TWA).

DATE: Comments must be filed in Docket 44827 and received no later than July 10, 1987.

ADDRESS: Documentary Services Division, C-55, U.S. Department of Transportation, 400 7th St. SW., Washington, DC 20590, Room 4107. Dockets 44730 and 44866 have been merged into Docket 44827 and comments should be filed in Docket 44827. Six copies should be submitted to the above address. Commenters should submit a self-addressed post card if they desire notification of receipt of their comments by the Department.

FOR FURTHER INFORMATION CONTACT: Sam Whitehorn or Gwyneth Radloff, at the above address or by phone at (202) 366-9307; Barry Molar, at the above address or by phone at (202) 366-9285; or Shelton Jackson, at the above address or by phone at (202) 366-5397.

SUPPLEMENTARY INFORMATION:

I. Summary/Overview

Based on data gathered in the Department's ongoing investigation into carrier scheduling practices, increases in the number of consumer complaints, and the documents filed by United, American, Delta, TWA and Continental Airlines, the Department has decided to request public comment on carrier scheduling practices. In addition, the above-mentioned carriers and Aviation Consumer Action Project also raised the issue of the need for disclosure of other airline service quality performance information and public comment is sought on these issues as well.

The NPRM first discusses the problem of scheduling and then sets out the possible regulatory solutions, including adoption of a disclosure rule, a performance standard, and a computerized reservation system (CRS) rule. Second, the NPRM discusses the other service quality performance issues raised in the petitions and answers to the Department. Then non-regulatory solutions that focus primarily on the scheduling problem, including legislative changes, are discussed. The Department has not yet determined which, if any, solution or set of solutions is appropriate and, thus, commenters should address each of the alternatives accordingly. Specific questions are raised to elicit information upon which a final determination can be made, and we ask that responses be numbered to correspond to the specific question. Commenters, of course, are not bound to limit their responses to the alternatives proposed or questions propounded.

II. Scheduling

A. The Problem: History and Background

The problem of schedule reliability or unrealistic scheduling is not a new one. The Civil Aeronautics Board, our predecessor in administering title IV of the Federal Aviation Act, adopted regulations in 1957 and continued to examine the issue regularly until 1984, when it rescinded its then existing reporting requirements and performance standard (14 CFR Part 234), and adopted the current policy statement on unrealistic scheduling (14 CFR 399.81(a)).

The Board grappled with performance standards, market definitions, and the safety implications of its rules. In addition, in devising rules, it sought to minimize reporting burdens. The Board's initial rule established an elapsed time performance standard. The Board required carriers to operate each flight within 15 minutes of scheduled elapsed time at least 75 percent of the time. Violations due to circumstances beyond the carrier's control that could not be reasonably foreseeable were excused. ER-223, 22 FR 6754 (August 22, 1957). In 1959, it added a flight delay reporting requirement based on arrival time (ER-251, 24 FR 757 (February 4, 1959)), and by 1961 concluded that flight cancellation information was needed. (EDR-26, 26 FR 3204, 3205 (April 14, 1961).

As a general matter, before 1984 the Board found that the reporting requirements provided benefits that justified their continuation. For example, in 1964, the Board concluded that continuation was justified because on-time performance had improved since the reports were instituted (ER-416/PS-25, 29 FR 14717, 14718 (October 29, 1964)) and because "carriers ha[d] made use of the on-time performance figures in their advertising."

In 1976, the Board expanded its reporting requirements to require carriers to report on the top 200 (from the original 100) largest domestic markets. ER-951, 41 FR 13332 (March 30, 1976). The Board also rejected requests to substitute system-wide on-time reporting statistics for individual flight statistics because system-wide reporting would not have "provide[d] a means for comparative evaluation by the Board, carrier management, and the public of each carrier's on-time performance, and thereby to create an incentive to better performance by all carriers." Letter dated October 7, 1968, from the Board to Eastern Airlines, rejecting its petition for rulemaking (Docket 19735). On-time performance reports evolved into two categories by 1964: on-time or within 15 minutes and over 15 minutes late. ER-416/PS-25, *supra*. The on-time arrival standard was consistent with the definition of late flights in the Board's elasped time performance standard, which the Board believed provided enough flexibility so as not to jeopardize safety. (The Board, in fact, had rejected a number of more stringent performance standards that might have affected safety.)

By the early 1980's, the Board's view of the benefits of its rule had apparently changed. In 1981, the Board waived the reporting requirement in response to the disruptions caused by the air traffic controllers strike. Reporting Directive No. 26 (August 10, 1981).

Then, in 1984, the Board rescinded Part 234 in its entirety because it believed that increased competition as a result of deregulation provided sufficient economic incentives to schedule realistically. ER-1393/PS-111, 49 FR 40565 (October, 17 1984) and EDR-301B/PSDR-79, 48 FR 29879 (June 29, 1983). The Board observed that it no longer needed the data from the on-time reports for enforcement purposes and that publication of the summarized on-time performance data by carrier and market "did not perform an important function in helping a passengers (sic) choose between competing airlines." EDR-301B/PSDR-79, *supra*, 48 FR at 29880.

The Department now believes a reexamination of the need for regulations in this area is warranted because it appears that a combination of factors may have created temporarily disincentives for carriers to provide realistic schedules, and thus consumers may be subjected to deceptive practices or unfair methods of competition.

Over the course of the past year, airline passengers have been experiencing increasing levels of flight delays. As the Department noted in Order 87-1-54, the current levels of flight delays are costly to consumers and cause considerable inconvenience. According to statistics compiled by the Federal Aviation Administration ("FAA"), over 417,000 flights in 1986 had a departure or arrival delayed by more than 15 minutes after the pilot's request for clearance, an average of 1,144 flights each day. At the 22 selected airports, which experienced 367,000 delays in 1986, the number of delays rose by thirteen percent between the first quarter of 1986 and the first quarter of 1987. While the number of delayed flights per 1000 operations has increased only moderately (from 33 to 36) over that period, as measured by the FAA, it appears that flight problems occur regularly on particular flights and at particular times of day.

The Department's initial investigation of carrier scheduling data to/from Atlanta (Order 87-2-4) revealed significant discrepancies between the carriers' published schedules and their actual operating experience. At Atlanta, the flight samples collected pursuant to our first investigation order (during six essentially good weather weeks at Atlanta) showed that more than 30 percent of all flight operations of two carriers to and from Atlanta were arriving more than 15 minutes late. In addition, nearly 100 regularly scheduled flights were more than 15 minutes late in arriving at least 70 percent of the times they were operated. Three flights in the sample were late 100 percent of the time they were operated. These data also indicate that the incidence of these delays is clearly related to the time of day when scheduled operations are most concentrated.

In the second round of airport investigations (Orders 87-4-17/18/19/20 concerning Boston, Chicago O'Hare, and Dallas/Ft. Worth; plus additional data on Atlanta), our analysis of the partial data received to date indicates that delays are indeed a widespread problem. The preliminary data shows arrival delays on one-quarter to one-half of all flight operations, depending on the particular carriers and airports involved.

Consumers growing dissatisfaction over airline scheduling problems is reflected in complaints to the Department. The Department received 4,893 consumer complaints in the first quarter of 1987, up 43 percent from the same period in 1986. While these complaints are not a scientific sample, they can indicate a trend. Almost one-third of the current complaints involve airline flight problems: delays, cancellations, and missed connections. In calendar year 1985, flight problems accounted for fewer than one quarter of the 11,142 complaints received by the Department. Altogether, total consumer complaints to the Department have increased 82 percent in the past two years, while complaints about delays, cancellations, and missed connections have increased 148 percent, from 649 in the first quarter of 1985 to 1,612 in the first quarter of 1987.

The airlines have also recognized consumers' increasing sensitivity to schedule delays and cancellations. Both American Airlines and Continental Airlines recently filed petitions for rulemaking requesting the promulgation of rules requiring disclosure of on-time performance and other service factors. Both petitions cite substantial increases in levels of consumer dissatisfaction as a basis for Department action in this area. United and Delta have also registered their support for regulations requiring disclosure.

While there is clearly a gap between the performance represented in carriers' schedules and the performance actually achieved, the cause of the problem is less clear. A large number of delays are apparently caused by weather. A partial cause of delays is also that the capacity of specific airports has been strained by the overall growth in air carrier operations since deregulation. This is exacerbated by the tendency of airlines to schedule large numbers of arrivals and departures at peak times of the day, which is the result, in part, of the hub and spoke systems now employed by the carriers. Such a tendency may largely be in response to airline consumers' desires to travel at peak periods.

Over the past several years, the Department has sought to address delays in a number of ways. In two instances, the Department supported industry-wide discussions (1984 and 1987), in an effort to get carriers to spread out operations during the day for specific airports where delays were most severe. The Department has also maintained on-going efforts to improve existing airports. In addition, from 1982 through 1986, the Department provided more than $3.8 billion from the Aviation Trust Fund for Airport Improvement Program grants, funding more than 5,000 specific safety, capacity, construction, and related projects at the nation's airports. The Department has also made operational and technological changes such as initiating new air traffic procedures that expand capacity and the National Airspace System Plan (NAS). The FAA recently implemented the East Coast Plan, which, among other improvements, increased the number of departure paths from 17 to 27 for the New York area airports; a similar plan for West Coast airports is now being developed.

The NAS Plan is a ten-year, $12 billion effort to modernize and improve the capacity of the air traffic control system; some 90 percent of the NAS plan contracts will be under way by the end of fiscal year 1987. These efforts have had, and will continue to have, a positive effect on airline performance.

Capacity is only part of the problem, however. Whatever the capacity of the system and whether or not it can be improved, carriers' schedules must and can take account of the operating environment. Given the numerous instances, noted above, where actual operations routinely fail to perform as scheduled, it appears clear that many flight schedules do not realistically reflect that environment and may in fact constitute a deceptive practice or an unfair method of competition.

Carriers have some incentives to present schedules that are overly optimistic. Indeed, as evidenced by the discussion of the Civil Aeronautics Board's involvement in this area, carriers have always competed vigorously on the basis of schedules.

The relatively recent evolution of computer reservation systems ("CRS's") as the primary vehicle through which air travel is sold and information on airline schedules is disseminated may have increased airlines' incentives to edit or "shave" their schedules. CRS's, used throughout the industry, enable agents to request from the computer system flight (and other) information in response to a customer's request. The information is displayed on a screen which has a limited number of "lines" per screen that typically can show only three to eight flight offerings. If the travel agent wishes to see additional flights, additional screens of information must be requested. Both departure time and elapsed time are among several important factors used by CRS vendors to determine display position. By reducing a flight's elapsed time, a carrier may be increasing its chances of selling seats on that flight. As the CAB found when it issued the CRS regulations (14 CFR Part 255), a flight's position within the displays can have a dramatic effect on the likelihood of seats being sold on that flight and the ability of the carrier offering the flight to compete effectively. EDR-466C, 49 FR 11644, 11652 (March 27, 1984). For example, if a customer asked for the flight that will get him or her to Chicago the fastest, and in actually it takes two hours for the trip, but one airline lists its elapsed time as 1:45, it will appear first on the screen regardless of reality.

At the same time, countervailing incentives for carriers to hold out realistic schedules may be inadequate. At present, available sources of information provide consumers with only limited information on the incidence of flight delays. The FAA collects monthly data on the number of delays at certain major airports, measured from the time the pilot requests clearance, and to our knowledge one private firm provides computerized information (The Peak Delay Guide) on projected delays for specific flights at major airports for a service fee. Neither of these information sources is widely disseminated at present and the FAA data is not intended to, nor does it, provide information on specific flights or on specific markets. Thus, consumers at the present generally have little information on flight reliability or on-time performance, and carriers may not suffer any direct penalty (by loss of business) for poor on-time performance. While an individual carrier might be able to state what its reliability is, and others might follow, comparisons would be difficult because their standards could be very different and the credibility of the information could be questioned. Consumers also may be able to determine to an extent the relative reliability of certain specific flights by determining where a flight originates, or if it is continuing on to another city—but this is not an easy task and would not necessarily provide sufficient information.

However, we may be underestimating the strength of the marketplace forces currently in place. Word of mouth and the switches made by individual passengers, over time, could be enough to reward carriers with good on-time performance and punish carriers whose schedules are not so reliable. In that case, governmental action would not be necessary. Moreover, current schedule difficulties might be a temporary phenomenon resulting from several recent airline consolidations.

B. Solutions: General Discussion

This section provides a general discussion of possible regulatory solutions that address unrealistic scheduling practices. The regulatory solutions proposed include a disclosure rule, adoption of a performance standard, and changes to CRS displays. Because of the interrelationship of these potential solutions, specific proposals are discussed later on, with a list of specific questions for commenters to address. Commenters should be aware that non-regulatory options, discussed separately in section IV, also include possible solutions to this problem.

The Department is particularly interested in comments addressing the safety implications of the various options. The establishment of an on-time performance enforcement standard (and to a lesser extent the disclosure options) could adversely affect carrier safety practices by increasing pressure on airline personnel to keep aircraft in service and meet flight schedules whenever possible. For this reason, for example, the CAB used an elapsed time enforcement standard that put no pressure on carriers to meet arrival or departure schedules at the expense of safety. There are also questions about whether a formal on-time enforcement standard would undercut DOT/FAA efforts to obtain full compliance with its maintenance requirements, unless the standard excuses delays and cancellations due to maintenance problems.

The Department specifically requests public comment on how the proposed disclosure and enforcement alternatives might affect the safety of airline operations and, if so, how that effect could be avoided. Specific questions are asked below following the detailed description of each alternative.

The Department has broad authority under section 411 of the Federal Aviation Act of 1958 (Act), as amended, to address unfair or deceptive practices or unfair methods of competition in air transportation. Other statutory sections, 204 and 407, bolster our authority to take appropriate regulatory action.

1. Disclosure Rule

A regulation could be structured that would provide information about the reliability of service, in terms of delayed and/or cancelled flights, to consumers. Making this information readily available to consumers might enhance market forces and provide an incentive for carriers to provide more realistic scheduling. This would not only give consumers more accurate information about a carrier's service, but also reduce passenger frustration with delays, since they would not be caught unaware of the actual time to reach their destinations.

Under deregulation, fare and service offerings have proliferated and consumers, generally, have a wide range of choices. The better informed the consumer is about the various relevant factors, the easier it is to make travelling decisions that meet the individual's needs. The data, once gathered and made available, could be used by carriers in their advertising and/or passed on by CRS vendors (either voluntarily or under DOT mandate) to travel agents and thus to the public.

If a disclosure rule is adopted, the particular information to be disclosed will need to be specified. While specific proposals are discussed below, as a general matter, commenters should consider:

(a) What should be disclosed? This addresses two aspects of the issue—what would be considered an appropriate measure of on-time performance or delay, and what type of flight performance information is needed (e.g., hub, market, flight). Should both delays and cancellations be disclosed? (Misconnections are addressed separately below.) In addition, to what extent should a rule provide for explanations of the causes of delay. Any criteria adopted to define a basis for delay would be uniform and only an unforseeable non-routine event would be considered a satisfactory explanation for a delay. Normal seasonal variations in weather conditions and fluctuations in air traffic control facility workload must be anticipated by carriers.

(b) Who will have to disclose the information? Information could be

required from all U.S. carriers, or only from U.S. carriers operating large equipment. It also could include or exclude affiliated companies that, for example, share airline codes. (This may not be an issue depending upon what type of market information is requested.)

(c) To whom must information be disclosed? Carriers could release the information directly, provide it to DOT or to a third party.

(d) How should disclosure be made? Carriers could be required to provide information on computer tape or disc, for example.

(e) When and how frequently must disclosure be made? Disclosure could be required monthly, bimonthly, or for some other time period, or continuously if a CRS-type disclosure option were selected.

2. Regulation Establishing Performance Standard

Unrealistic scheduling constitutes a violation of section 411 (14 CFR 399.81). We note that in adopting 14 CFR 399.81, the Board expressed its belief that unrealistic scheduling could also constitute an unfair method of competition. ER 1393/PS-111, *supra*, 49 FR at 40567.

A performance standard would establish a "bright line" threshold for carriers by stating explicitly a level of performance below which they risk enforcement action. We note that the Board included a performance standard based on elapsed time performance in 14 CFR Part 234.

Any performance standard must be carefully balanced. On the one hand, a standard that is too strict may have undesirable results. In addition, in many instances, delays may be the result of unforeseen events outside the control of a carrier, such as weather problems, air traffic control equipment problems, or mechanical failures. Carriers should not be held responsible for unpredictable delays. Of course, if such delays are a routine occurrence, a carrier's schedule would be expected to be adjusted to reflect them. In addition, it appears that throughout its administration of Part 234, the Board was concerned that an arrival or departure performance standard might put undue pressure on carriers to achieve schedule reliability at the expense of safety. However, a performance standard that is made too flexible in order to accommodate some of the concerns outlined above may do little to improve schedule reliability.

If a performance standard is adopted, a number of elements will have to be selected. While two specific options are discussed below, as a general matter, commenters should consider:

(a) What should be the basis for measuring performance? There appear to be three choices: elapsed time performance, arrival time performance or departure time performance. An arrival time standard may more closely reflect consumer concerns about schedule reliability, but the Board preferred an elapsed time standard at least partially because it believed that this standard presented fewer safety risks. Departure time (pull-back) performance is a measure under the most direct control of a carrier, but its interest to the consumer may be minimal.

(b) What should be the performance threshold? *i.e.*, what percentage of flights must be performed on-time? Should performance be measured on the basis of individual flights, all operations in a city-pair market, a carrier's system as a whole, or just for its hubs?

(c) How should a late flight be defined? The Board's standard permitted flights to be operated up to 15 minutes longer than scheduled elapsed time without treating it as a late flight. The FAA uses the 15 minute grace period in its current definition of a late flight.

(d) Over what time period should performance be measured? Performance could be measured, for example, monthly, by calendar quarter, or based on a rolling three month average.

(e) Should there be any provisions in the rule for excusable delay? For example, the Board's performance standard provided that delays caused by circumstances beyond a carrier's control that could not be reasonably foreseen would not be counted.

3. Regulation of CRS Displays

As discussed above, there may be an advantage for a carrier to have its flights listed as high as possible on the first display screen of a CRS. CRS owners are required to order their displays of flights on the basis of objective factors. 14 CFR 255.4 Although vendors vary in the formulae (algorithms) they use to rank flights for display, most place substantial weight on two factors: elapsed time and the difference between requested departure time and scheduled departure time ("displacement"). The choice of these factors and their weights are alleged to reflect passenger preferences. The CRS owners rely on schedule information provided by the carriers. Of course, the schedules reflect carriers' claims concerning scheduled departure and scheduled elapsed time. While some carriers may adjust schedules to reflect actual operating times, our preliminary investigations indicates that some carriers may have schedules that do not take into account the extent to which a carrier does or does not actually perform according to its schedule. Some have suggested that these circumstances provide an incentive for carriers to adjust their schedules to improve the listing of their flights in CRS.

The Department is considering whether regulating CRS display algorithms would provide a disincentive for unrealistic scheduling, and if that disincentive would result in a significant reductions in delays. In addition, since CRS's are a major source of information for consumers on flight schedules, the Department is examining whether requiring CRS's to display information on schedule reliability is both feasible and the most effective way to provide consumers with the type of information that they need to make informed choices. United, however, believes that using CRSs as a means of disclosure would not be effective because passengers do not generally have direct access to the screen and because of the difficulty in condensing the voluminous material.

Of course, any regulation of CRS displays raises a number of issues, which we address with specific questions below. The primary issue, however, is whether regulating CRS displays is necessary, effective, or justified. In addition, alternative regulations would impose different costs on vendors, consumers, and carriers.

Specific proposals reflect two alternative approaches: one to require CRS's to display data on schedule reliability and one to require CRS vendors to modify their algorithms. Each approach presents some unique policy issues, which we address below.

C. Specific Proposals/Questions

1. Disclosure Rule

DOT is considering four types of disclosure regulation, as follows:

(a) *Require airlines to report flight performance and cancellation data to DOT monthly for flights in specified markets. (Re-institute the CAB disclosure rule or some modified form of the CAB rule).*

Under the old CAB regulations, all carriers were required to report on the performance of all flights in the top 200 city-pair markets. The reports indicated the number of times each month a flight was on time (within fifteen minutes of scheduled arrival time) or cancelled. Reports were due 45 days after the close of a month and summaries of carriers' overall on-time performance, by market, were then made public by the CAB. The

reports did not include the time of the day of flights.

One alternative is to re-institute the CAB requirement without modification. Several of the questions that follow seek specific information on that alternative, and on its costs and benefits.

We are also considering modifications to the former CAB requirement. One variation of the CAB rule, for example, would be a disclosure rule that provides information on the time of day of frequently delayed flights, by requiring carriers to provide a simplified form of the flight data now being submitted in the Department's delay investigation. The carriers involved in the investigation already have programmed their computers to prepare monthly reports of scheduled and actual departure and arrival times of flights in the largest markets.

Because of the computerization of the industry, it is also possible that reports now could be submitted within 10 days after the end of each month. Also, the number of markets covered could be increased. The top 200 markets represent less than 50% of all passenger trips (the percentage of delays accounted for by these markets is not known). However, by adding 100 more markets, as suggested by TWA, the proportion of total passengers covered increases by less than 10%. As an alternative, we could require carriers to provide data on all flights in smaller markets which are late some specified percentage of the time.

United is in favor of requiring disclosure of the percentage of flights in each nonstop market that leave within 15 minutes of the scheduled departure time and arrive within the same period of the scheduled arrival time. This, according to United, would provide consumers with information on on-time departure, on-time arrival, and also elapsed time. In addition, United contends that supplying such information for all non-stop markets, instead of the old CAB limitation to the top 200 markets, would not be difficult for carriers and would be more useful to consumers. Delta generally agrees with United, but adds that the cause of delays also should be reported so that a more accurate picture of delays is made available. The Board considered such a request at one time, but it found that reporting the cause of delay would be "unrealistic." ER-416/PS-25, *supra* at 29 FR 14718. If the final rule includes such a requirement, the Department anticipates that any reporting requirement would only include unforeseen circumstances, and not occurrences that carriers can and do anticipate.

The proposed rule also would require that carriers provide cancellation information by flight for the markets covered by the requirement.

(b) *Require carriers to report monthly to DOT the percent of flights by hub and by entire system that depart from the gate more than 15 minutes behind schedule, and require carriers to report monthly cancellation data on a systemwide basis, using available seat miles as a measure. (Continental proposal).*

Continental proposed that carriers be required to report monthly to DOT the percentage of flights, by "hub" (airports at which the carrier has 75 or more departures per day) and on a systemwide basis, that depart from the gate (i.e., "push-back" time) more than 15 minutes behind schedule. Continental claims that this standard focuses on delays under the direct control of the carrier by eliminating counting of many delays, such as air traffic control delays and actual flight time delays, which are unpredictable because of the ATC system. The aggregation of data on a hub basis, Continental claims, would provide consumers with efficiency data, would not be burdensome to produce and would avoid "misleading" market-by-market data.

Under Continental's proposal, cancellation information would be reported based upon a systemwide completion performance, measured by dividing systemwide available seat miles ("ASM's") actually flown by scheduled available seat miles.

United and Delta contend that Continental's proposed on-time reporting requirement would not reveal carriers' attempts to distort scheduled elapsed time to gain a CRS advantage and would not provide information on how long the flight takes. In addition, they contend that reporting information on a market-by-market basis is not burdensome, despite Continental's claims, and was done by all carriers for years under the CAB rules. American submitted a separate proposal which is discussed under C.1.(c).

Concerning Continental's cancelled flight information proposal, United also supports a disclosure rule, but based upon the systemwide percentage of flight segments (as opposed to ASM's) completed as compared to flight segments scheduled. United argues that this would give consumers useful information on the likelihood that a flight would be completed. Delta agrees with United. United and Delta argue that the ASM comparison provides no useful information to consumers, and could result in under-representation of cancelled flights in short-haul markets.

(c) *Require carriers to report flight arrival and departure performance and cancellation data monthly to DOT for specified markets, in standardized computerized form, and encourage or require CRS vendors to include such data in their CRS displays (American proposal).*

American, in its petition for rulemaking, proposes that on-time arrival and departure performance information be provided for each flight in the top 250 city-pair markets and for hubs. The information would be provided in a standardized format on computer tape to DOT or a third party, consolidated and then made public. In addition, American would have the Department either request or mandate that CRS vendors provide such data in comparative service quality displays.

Concerning cancelled flight information, American suggests that the data be reported based on flights scheduled and operated. This information is now provided on Form 41, Schedule T-3(A) but American argues that it should be supplied via computer tape so that it can be consolidated into a service quality data bank.

(d) *Require carriers to adjust flight times of delayed flights in schedules held out to the public (including CRS's, the Official Airline Guide (OAG), and each carrier's own schedules and advertising).*

This proposal would require carriers to adjust schedule times for frequently late flights. Flight times for all flights that were late more than a specified percentage of the time (25, 35, and 50 percent are proposed as alternative benchmarks here) during the previous month would have to be adjusted for the succeeding schedule period. A three month time frame is also proposed, but comments are specifically sought on other appropriate time frames. The proposal would require carriers to add the median or average number of minutes these flights were late to the scheduled elapsed time.

(e) *Department Compilation of Specific Data and Issuance of Airline Ratings.*

Under this option, the Department would require that carriers provide raw data on a number of indicators, such as arrival delays, departure delays and misconnections. The information could be submitted, as discussed in options (a) through (d), in a number of forms (hub, market, system-wide) and formats (hard copy or computer tape). The Department would then apply a weighting system to establish a rating for each carrier. The

rating would provide consumers with a standard quality guide upon which to base travel decisions.

The Department, before issuing a rating, would provide carriers with a proposed rating determination, and an opportunity to discuss informally potential errors in the basis for the rating. The letter notifying the carrier of the preliminary determination would provide information on the carrier's opportunity for such discussions. Any discussion, however, would be limited to reviewing errors in the basis for the rating. This opportunity for discussion would be limited and no further appeal rights would be provided. After such a meeting, the Department would provide the carrier with its final rating determination and then publicly issue all carrier ratings. The rating would be provided quarterly based on one full quarter's data.

The following proposed rulemaking language reflects the disclosure options (a–c). The alternatives are identified and changeable elements are marked in brackets. The proposed section on adjustment of flight times reflects disclosure option (d). The proposed section on airline ratings reflects options (e).

§ 234.___ Purpose.

The purpose of this part is to set forth required data that air carriers must submit to the Department [or to CRS vendors or to third parties] in computerized form [or other form] so that information on air carriers' quality of service can be made available to consumers of air transportation. [It also sets forth an on-time flight performance standard.]

§ 234.___ Definitions.

For the purposes of this part:

"Cancellation rate" means the percentage of scheduled flights or group of flights not operated during a given period.

"Flight" means a nonstop [interstate or overseas] scheduled passenger flight segment operated between two points, pursuant to a published schedule.

"Late" or "late flight" means a flight that arrives [departs] 15 minutes or more after its published time. The "published" time of a flight shall be that time shown in the Official Airline Guide, in the schedule displays of carriers and CRS vendors, or in other publications intended for the guidance of the travelling public.

"On-Time" means a flight that arrives [or departs] not later than [15 minutes] after its published time.

"On-Time Performance" means the percentage of the time a specific flight, or group of flights, operates on-time.

"[200] largest domestic city pair markets" means the [200] pairs of points with the highest revenue passenger volumes as stated in Table 6 "Domestic City-Pair Summary: Top 1000 Ranked City Pairs in terms of Passengers" in the Department's *Domestic Origin-Destination Survey of Airline Passenger Traffic,* as shown in the current "List of City Pairs for use in Reporting On-Time Performance."

§ 234.___ Applicability.

This part applies to [any air carrier certificated under paragraphs (d)(1), (d)(2), (d)(5) or (d)(7) of section 401 of the Federal Aviation Act insofar as it is engaged in passenger air transportation, other than service conducted with "small aircraft" as defined in Part 298 of the Department's Regulations, 14 CFR Part 298]. This part does not apply to charter flights.

§ 234.___ Reporting of on-time performance.

(a) Each [certificated] air carrier scheduling nonstop passenger service flights shall report, on a [monthly] basis, for each of its non-stop flights scheduled [in the 200 largest domestic city-pair markets] the following information:

(1) Flight number.

(2) Origin and destination airport codes.

(3) Scheduled departure and arrival times, as set forth in schedules held out to the public.

(4) Actual departure and arrival times for each operation of the flight.

(5) Number of times the flight was cancelled.

(6) Percentage of flights actually operated that [arrived and, separately, departed] late.

(7) For each operation in which the flight was cancelled or arrived [or departed] 15 minutes or more later than scheduled, a special indicator for those which were due to a maintenance problem. [Misconnections are addressed below.]

§ 234.___ Form of reports.

Except where otherwise noted, all reports required by this part shall be filed with [the Department within [15 days] of the end of the [month] [in the form of computer tape, disc, or via electronic transmission to a central data base] in the form and manner set forth in Appendix A (to be specified before the final rule). [Small carriers without access to computer facilities may file the required data on hard copy]

§ 234.___ Adjustment of flight times.

(a) Each carrier shall ascertain on a monthly basis, the on-time performance of each flight that it operated on a regular basis during the preceding [three months].

(b) Based on that review, the carrier shall increase the scheduled elapsed time for each flight that had an on-time performance factor of less than [75] percent during the preceding [three months], by the [average, median] number of minutes the flight was late during that period; i.e., [the preceding three months] in schedule submittals to CRS's and the OAG.

(c) The schedule adjustment shall be completed by [the end of the month] in which the corresponding schedule review is made.

Part 234.___ Airline rating.

Based on information provided pursuant to section 234.___, [addressing market information] each U.S. air carrier receives an airline service rating quarterly.

(a) The rating is based on arrival delay, departure delay and misconnection information. The weight assigned to each factor is: 40 percent for arrival delay; 30 percent for departure delay and 30 percent for misconnections.

(b) Carriers are required to submit the quarterly data within 15 days after the last day of each quarter. The rating is released 60 days after the close of the fiscal quarter.

(c) Carriers are provided notification of the rating within 15 days of the submission date and have 7 days to request an informal discussion to discuss the potential errors in the basis for the proposed rating. Carriers that requested and had an informal meeting are then notified of the final rating decision within 10 days of the informal meeting. This notification constitutes the Department's final determination.

Questions on Scheduling Disclosure Options

Note: For each of the questions below, commenters should provide the basis for any response, and any studies, reports or data to support the responses.

1. *Safety:* Any regulation considered by the Department must be evaluated in terms of the impact on safety. The Department does not consider a rule that would cause carriers to place a higher value on on-time performance than on safety of operations to be beneficial. Commenters therefore should address whether, and specifically how, any of the four disclosure regulations described above affect airline

operations in a way that would impinge on safety. For example, would such a rule put undue pressure on airline personnel to keep aircraft in service and meet flight schedules? How would such a rule affect compliance with FAA maintenance schedules and requirements? If an adverse impact is possible, how could such an effect be avoided?

2. *Type of data:* What type of flight performance and cancellation data should be required to be reported? Should carriers submit data by individual flight or should carriers aggregate the data in some form? If aggregated, should each submitting airline aggregate it by hub, by city-pair market, or systemwide? If hubs, how should hubs be defined? If data is to be flight-specific, should each submitting airline be required to indicate the actual and the scheduled arrival and departure times for each flight? Or simply indicate how many times each flight was cancelled or failed to operate "on time" (e.g., 15 minutes or more later than the scheduled arrival time)? Are late departure times, as compared to late arrival times, a relevant benchmark for lateness? What percentage level of late flights is appropriate to use in defining "frequently late flights"?

3. *Scope of data (markets):* If flight or city-pair data is required, should the data be required for all markets or should it be limited to certain markets? For example, should it be limited to domestic markets (or domestic flights)—to the largest markets (e.g., the top 200 city-pair markets)—to flights operated by a carrier, or city pairs served from, its hubs—to the hub airports of each carrier?

4. *Explanatory detail:* Should carriers also be required or permitted to provide a breakdown of reasons for delayed and cancelled flights? Should carriers be required to identify the causes of specific delayed flights? Why? If so, what categories should be used, based on what definition, and with what, if any verification requirement? Should only non-routine occurrences be reported? Is a definition of non-routine needed? If so, please provide specific language.

5. *Airlines:* Should all scheduled U.S. passenger airlines be required to report the data? Or should small air carriers or commuter airlines be excluded from the requirement? Why? Are there alternative ways to gather and disseminate data that would have less impact on small or commuter airlines? What are they and how would they help? In addition, are passengers on small airlines more or less affected by unrealistic scheduling? What are the benefits that each of the alternatives could have for the carriers?

6. *Reporting deadline:* How soon after the end of the month should carrier reports be required to be submitted to DOT? 10 days? 15 days? 30 days? Why?

7. *Dissemination of data to the public:* How should DOT or a third party disseminate the data to the public? If the data is voluminous (e.g., flight-specific rather than aggregated by carrier and by hub), how can it be summarized most usefully? For summarization purposes, what standard of lateness should be used to measure the number of delayed flights (e.g., 15 minutes late in arrival time)? Should the number or rate of delays be summarized by carrier? Why? By carrier and city-pair market? By listing the most frequently delayed and cancelled flights? Why? Should more detailed data be made available through the National Technical Information Service or the Government Printing Office for a fee? Why?

8. *Consumer benefits:* What benefits would flight performance and cancellation information provide to the travelling public? How could the value of these benefits be quantified? What level of detail of data would be optimum for use by consumers? To what extent would flight performance information affect consumer choice as between airlines and as between different flight times? Would the consumer benefits be similar if the information were disclosed in a highly aggregated form—e.g., carrier data aggregated by hub or systemwide—as compared to flight-specific data? Would aggregated data provide a valid or meaningful basis for consumers to select flights or airlines on which to fly? How would cost be affected by aggregation of data or choice of markets to be included? Would city pair or flight data for carriers' entire systems be more costly to produce than data for a limited group of markets?

9. *Costs of reporting:* How costly would it be for carriers to report flight performance and cancellation data to DOT? Would certain types of airlines bear a disproportionate cost in submitting the data to DOT compared to other types of airlines?

10. *Impact on competition:* What kind of impact, if any, would the dissemination of flight delay and cancellation information have on the nature of competition in the airline industry? Would it generate increased competition on the basis of service quality? Would the choice of different disclosure requirements lead to different effects on quality of service competition? Would it lead to reduced low-fare competition? Are there ways to gather and disseminate the data that would lessen the impact? What are they and how would they help?

In addition to the questions posed above concerning the safety implications of any proposed rule and the types of information to be provided, commenters should address the following questions:

11. What types of information should be relied upon to develop a carrier rating? Should it include factors other than arrival and departure delays, and misconnections? Why?

12. What competitive effect would such a rating have? Would a rating have less of an adverse competitive effect than other alternatives being proposed here? Why?

13. What weight should the Department accord each of the factors relied upon? For example, the Department could weight the rating so that arrival displays accounted for 40 percent of the rating, departure delays 30 percent and misconnections 30 percent? Please explain the value of the various weights.

14. Questions concerning the definitions of arrival and departure delays, and misconnections are addressed elsewhere. Commenters should address the need for such definitions under this proposal too.

15. How would the Department rate a carrier that did not rely on a hub and spoke operation? Would such a rating, particularly with a weighting factor based on misconnections, be of use to passengers that rely primarily on point to point flights?

16. How often should such a rating be provided? Quarterly? Monthly? Annually? For what time period should ratings apply?

17. Should separate categories be established for different size carriers i.e., regional carriers and large carriers? Should ratings be established for regional carriers?

18. Should the ratings be in broad general categories, e.g., "A", "B" etc., or more detailed, such as a 0–100 scale? Why?

2. Performance Standard

DOT is considering two types of regulation that would establish an airline scheduling performance standard for determining when failure to meet schedules would be considered unfair or deceptive under section 411 of the Federal Aviation Act. Both use the format of the Board's elapsed time performance standard. One performance standard would be based on elapsed flight time, and one would be based on arrival time.

Under the Department's current authority (14 CFR 399.81), we have the ability to take enforcement action against individual carriers for unrealistic scheduling practices and in fact, as noted earlier, investigations are now under way for a number of airports. The alternative considered here goes beyond the individual enforcement approach in that it would set a standard for carriers, rather than establishing such a standard on a case-by-case basis.

(a) *Elapsed time standard.* This proposed rule would require a carrier to design all published schedules so that the carrier could complete a minimum of 75 percent of flights operated with an elapsed time of more than 15 minutes longer than scheduled elapsed time. The rule would also require carriers to actually complete at least 75 percent of flights in accordance with this standard in any three-month period. It would define the failure to do so as a violation of the rule, unless the carrier shows that the failure to do so was due to circumstances beyond its control that could not have been reasonably foreseen. Regularly recurring weather, air traffic control equipment, or airport congestion problems would not be considered as reasonably unforeseeable. Commenters are invited to propose and discuss alternative elements.

(b) *Arrival-time standard.* This rule would require a carrier to design all published schedules so that the carrier could reasonably expect to complete each nonstop flight segment not later than 15 minutes after scheduled arrival time at least 75 percent of the time. The rule would also require each carrier to meet this standard for at least 75 percent of the flight segments actually operated over a three-month period. A failure to meet the 75 percent performance standard would be a violation of the rule unless the carrier showed that the failure was due to circumstances beyond its control that could not reasonably be foreseen. The second proposed rule is identical to the first except that the standard is based on arrival time rather than elapsed time. The Department is willing to consider whether this difference justifies differences in other elements. A variation of this option could be based on departure time.

The proposed rulemaking language in the following two sections reflects both performance standard options. The alternatives are identified and changeable elements are marked in brackets.

§ 234.__ Realistic scheduling requirement.

(a) For each flight scheduled by a carrier, all flight schedules published for the guidance of the travelling public shall be designed so as to enable each air carrier subject to this part to safely perform (in accordance with all applicable legal requirements of the Federal Government), at least [75] percent of all flights actually operated with elapsed times [arrival times] not greater than [15] minutes longer [later] than scheduled elapsed [arrival] times during any [three-month period].

(b) Each carrier subject to this part shall perform a minimum of [75] percent of flights actually operated on-time as scheduled pursuant to each such scheduled flight during any [three-month] period. Flights delayed due to a maintenance problem will be excluded in determining compliance with this provision.

§ 234.__ Violations.

The failure of a carrier to achieve the on-time performance requirements of paragraph (b) shall constitute a violation of this part and section 411 of the Act, unless the carrier shows that its performance was due to conditions which are not subject to its control and also could not have been anticipated in the exercise of reasonable prudence. [Normal seasonal variations in weather conditions and time-of-day fluctuations in air traffic control facility workload must be anticipated by carriers.]

(Selection of either option for a performance standard would require a conforming change to 14 CFR 399.81.)

Questions

DOT requests comments and information on the specific form that an enforcement regulation should take. Below are the kinds of information and comments that DOT seeks.

19. *Safety:* Any regulation considered by the Department must be evaluated in terms of the impact on safety. The Department does not consider a rule that would cause carriers to place a higher value on on-time performance than on safety of operations to be beneficial. Commenters therefore should address whether, and specifically how, a performance standard regulation affect airline operations in a way that would impinge on safety. For example, would such a rule put undue pressure on airline personnel to keep aircraft in service and meet flight schedules? How would such a rule affect compliance with FAA maintenance schedules and requirements? If an adverse impact is possible, how could such an effect be avoided?

20. *The benchmark:* Should a performance standard be based on actual flight operations conforming to elapsed time, arrival time, or some other benchmark? Should the level of conformity be 75 percent or some other amount? Should the standard apply to flights individually (that is, by flight number) or to some higher level of aggregation (e.g., all flights within a city-pair market, all flights from or to a particular hub, or each carrier's entire system)? How should a late flight be defined? What time frame should be established for the standard (e.g., each month? quarterly? annually?)

21. *Enforcement with or without disclosure:* If a disclosure requirement is established, is a performance standard also necessary? Or should a performance standard be established without an ongoing reporting requirement?

22. *Airlines:* Should a performance standard apply to all airlines?

23. *Domestic vs. international flights:* Should the standard apply only to flights by U.S. airlines within the U.S.?

24. *Extenuating circumstances:* Should extenuating circumstances be taken into consideration in the rule (e.g., delays caused by circumstances outside the control of, *and* unpredictable by the airline would not be counted)? If so, what categories should be used, based on what defintion, and with what, if any, verification?

25. *Consumer benefits:* What benefits would a performance standard provide to the travelling public? How could the value of these benefits be quantified?

26. *Costs:* What costs would airlines incur in complying with a performance standard? Would certain types of airlines bear a disproportionate cost compared to other types of airlines? What costs would result from an enforcement action? e.g., lost revenues or additional advertising costs?

27. *Impact on competition:* What kind of impact, if any, would a performance standard have on the nature of competition in the airline industry? Would it generate increased competition on the basis of service quality? Would it lead to reduced low-fare competition?

3. CRS Display Regulation

DOT is examining four types of approaches to regulating airline CRS's. Three of these options would require that vendors have access to on-time arrival information of one kind or another. If we adopt independent reporting requirements, the data would likely be available to CRS owners and it would be unnecessary to report separately to vendors. The specific proposals are drafted as if this were the case. If DOT adopts one of the first three approaches to CRS displays without adopting independent reporting

requirements, the final rule would have to include a requirement that carriers report appropriate on-time performance data to CRS owners.

a. *Require CRS vendors to identify consistently late flights in the primary display screen.* This proposed rule would require CRS vendors to identify in their primary schedule and availability displays, all flights that are frequently late or cancelled. A frequently late or cancelled flight would be defined as any flight which had more than 25 percent of scheduled operations cancelled or arriving more than 15 minutes late in the preceding three months. Vendors would be required to update this information monthly. The identification could be accomplished by placing an asterisk or other symbol by late and cancelled flights, so that CRS users could readily determine that such marked flights were frequently late or cancelled. The rule would also specify that operations between the same pair of points with departure times that were within one-half hour of each other from month to month would be counted as the same flight for purposes of the rule. This is intended to assure that carriers cannot circumvent the rule by changing flight numbers or making minor adjustments in schedules.

If this option is adopted, 14 CFR 255.4 would be amended by adding a new paragraph (e) to read as follows:

(e) (1) On the basis of flight service quality information provided by [the Department, air carriers] each month, system vendors shall tag frequently late flights and flights cancelled more than [five times per month] on the primary CRS display screens. Flights are considered frequently late if they are more than [15] minutes late more than [25, 35, 50] percent of the time over [one month, three consecutive months]. The tagging must be applied consistently to all carriers, including the system vendor, and to all markets.

(2) Any flight that is scheduled to depart within one-half hour of a flight operated in the same direction between the same pair of points during the previous [one month, three consecutive months] shall be considered the same flight for the purposes of this section, even if the flight number or arrival or departure time has changed.

(3) Vendors shall update their display of frequently late and cancelled flights not later than the first day of each month based on data received the previous month.

b. *Require CRS vendors to display flight schedule reliability data in secondary displays.* The proposed rule would require each CRS owner to construct an information display that would provide the following information for each nonstop flight segment in a city-pair: current flight number, carrier or carrier designator code; number of operations scheduled in previous month; number or percent of operations completed; number or percent of operations cancelled; and number or percent of operations arriving more than 15 minutes after scheduled arrival time. The vendor would be required to update the display monthly based on the results of the previous month's operations. This approach would provide more complete information to the travel agent on delays. However, the travel agent would be required to view supplemental screens to obtain the additional information.

If this option is adopted, 14 CFR 255.4 would be amended by adding a new paragraph (e) as follows:

(e)(1) On the basis of flight information provided by [the Department, air carriers], system vendors shall, for each flight listed in their primary schedule and availability displays, show the following flight performance information in their systems on a separate screen:

[(i) Carrier or designator code as defined in 14 CFR § 256.3.

(ii) Current flight number.

(iii) Number of operations scheduled in previous month.

(iv) Number or percent of operations cancelled during previous month.

(v) Number or percent of operations [arriving or departing] more than [15] minutes after scheduled [arrival or departure] time.]

c. *Require CRS vendors to assign a penalty factor to frequently late flights.* This proposal would require CRS vendors to alter their algorithms by adding 60 minutes to the scheduled elapsed time of frequently late or cancelled flights when establishing the ranking of flights for primary availability and schedule displays. A frequently late or cancelled flight would be defined as in proposal 3(a), above. CRS owners would be required to review this penalty program monthly based on data from the previous month, and to make appropriate adjustments. Thus, if the on-time performance of a penalized flight improved to a specified percentage, for example, less than 25 percent late or cancelled, the vendor would be expected to eliminate the penalty. It is our understanding that under current CRS operating methods, a 60 minute increase in the elapsed time of a nonstop flight segment would also result in a 60 minute increase in the elapsed time of all connections that include that nonstop flight segment. Since a delay on one leg of a connection could cause a delayed arrival or missed connection, we have no objection if this effect also applies to connections involving penalized flight segments. We have proposed a uniform penalty of 60 minutes. A greater or lesser penalty may be appropriate; an alternative would be to penalize each late flight by the average number of minutes it was late in the previous three months.

If the Department adopts this option, 14 CFR 255.4 would be amended to add a new paragraph (e) as follows:

(e) (1) Based on data [supplied by the Department, air carriers] each month, system vendors shall, in ordering flights for the primary schedule and availability displays, add 60 minutes to the scheduled elapsed time of frequently late flights and flights cancelled more than [five] times per [month]. The penalty factor must be applied consistently to all carriers, including the system vendor, and to all markets.

(2) Flights are considered frequently late if they are more than [15] minutes late more than [25] percent of the time over [one month, three consecutive months]. Any flight that is scheduled to depart with one-half hour of a flight operated between the same pair of points in the same direction during the previous [month, three months] shall be considered the same flight for the purposes of this section, even if the flight number or arrival or departure time has changed.

(3) System vendors shall adjust the penalty factors required above not later than the first day of the month after flight delay information is received.

d. *Require CRS vendors to modify flight ranking algorithms, so as to reduce incentives for carriers to schedule unrealistically.* The proposed rule would require CRS vendors to modify their display algorithms so that differences in elapsed time of less than 30 minutes between two flights would not affect the relative ranking of those flights as against each other. In addition, the proposed rule would require CRS owners to eliminate penalties for displacement from requested departure time as a ranking factor for all flights departing within 30 minutes before and 30 minutes after the departure specified in a booking inquiry.

If the Department adopts this option, 14 CFR 255.4 would be amended by adding a new paragraph (e) as follows:

(e) In ordering flights in their primary schedule and availability displays, system vendors shall not use an algorithm that assigns any weight to

differences in scheduled elapsed time between flights of less than 30 minutes. In addition, the system vendor shall employ an algorithm that assigns no weight to displacement from requested departure time for flights scheduled to depart within 30 minutes before and 30 minutes after the requested departure time.

Questions

DOT requests comments and information on the specific form that a CRS regulation should take. Below are the kinds of information and comments that DOT seeks.

28. *Safety:* Any regulation considered by the Department must be evaluated in terms of the impact on safety. The Department does not consider a rule that would cause carriers to place a higher value on on-time performance than on safety of operations to be beneficial. Commenters therefore should address whether, and specifically how, any of the four CRS display regulations described above affect airline operations in a way that would impinge on safety. For example, would such a rule put undue pressure on airline personnel to keep aircraft in service and meet flight schedules? How would such a rule affect compliance with FAA maintenance schedules and requirements? If an adverse impact is possible, how could such an effect be avoided?

29. *Need for Delay Information in CRS's:* Is there a need for travel agents and consumers to have Federally-required CRS flight information relating to delays and cancellations? If so, which of the CRS regulations listed above best meet this need? If information is needed, commenters should address specifically what types of information would be most useful to consumers and to travel agents.

30. *Airlines and Flights Affected:* Should a CRS regulation apply to all airlines or should certain airlines be exempt? Should a CRS regulation apply to all flights or should certain flights (e.g., international) be exempt?

31. *Timing:* If airlines must submit certain information to CRS vendors and CRS vendors must incorporate that information into CRS displays, what deadlines for submission and incorporation are feasible and appropriate?

32. *Criteria for Designating a Flight as Frequently Late or Cancelled:* What criteria should be used to designate a flight as late or cancelled in a CRS display?

33. *CRS Algorithms:* How much of a penalty factor should be incorporated into CRS algorithms for frequently late or cancelled flights? Alternatively, should the CRS's algorithm weights for "elapsed time" and "displacement time" be modified to ignore minor differences in time—or be set at a maximum weight of 35% each—or some other maximum amount?

34. *Costs:* What would be the costs to airlines and to CRS vendors of requiring the display of delay and cancellation information in CRS's or of changing the algorithm? We expect that different alternatives would impose different costs on vendors and other carriers. In addition, since travel agents and reservations agents will need to take additional time to review the information and discuss it with consumers, the personnel costs for the reservations process will be increased. What are those costs? Would CRS vendors pass their increased costs on to the participant airlines and, if so, how? Would costs also be passed on to consumers and, if so, how?

35. *Benefits:* What benefits would consumers realize from the display of delay and cancellation information in CRS's? Two types of benefits appear to be obtainable with a CRS display regulation. One involves the benefits of providing consumers with service quality information at the point of sale that will facilitate quality competition and assist the delay conscious consumer in selection of flights. The second involves the benefits of reducing CRS-induced incentives to schedule unrealistically. How will the choice of a rule affect the attainment of each type of benefit? Are there any other benefits from the rule? How could the value of these benefits be estimated?

36. *CRS Regulation with or without Disclosure and Enforcement Regulation:* Should a CRS regulation be issued in conjunction with a disclosure and/or enforcement regulation? Or would some form of CRS regulation be adequate and appropriate without a requirement for disclosure or a performance standard?

37. *Impact on competition:* What kind of impact, if any, would a CRS regulation have on the nature of competition in the airline industry? Would it generate increased competition on the basis of service quality? Would it lead to a reduction in lowfare competition?

III. Other Service Quality Indicators

In addition to on-time operations and flight cancellations, various airline pleadings and legislative proposals have suggested other consumer service factors that may warrant a disclosure regulation. These address airline performance in such areas as delays in carrier telephone reservation response times, lost or misdirected baggage, denied boardings, misconnections and cabin amenities. These suggestions are premised on the notion that the absence of useful information about the relative quality-of-service performance of competing airlines reduces the ability of consumers to make intelligent choices and provides few incentives for air carriers to provide the best service. Proponents contend that providing consumers with information on various quality-of-service attributes would place maximum reliance on competitive market forces to correct airline service quality problems.

Consumers also have expressed concerns about airline practices in selling discount fares. They complain that advertised fares are often unavailable and have suggested that the Department establish standards for regulating these practices.

A. Carrier Proposals for Service Quality Disclosure

Continental Petition: Continental's petition would require air carriers to submit monthly data on the percentage of telephone calls (to make reservations) systemwide that are answered within 20 seconds or less and the average number of seconds taken to answer all calls. Carriers also would be required to report data on the number of customers whose baggage is properly handled per 1,000 passengers enplaned system wide and for each hub.

United Answers: In its answers to Continental's petition, United opposed the proposed requirement that air carriers submit telephone reaction time data because it is unreliable and irrelevant; the averages would be a poor measure of air carriers' ability to serve the public because they can be manipulated and do not account for the differing capacities of carriers' communications systems. In addition, United noted that carriers have a tremendous economic incentive to provide a quick reaction time to obtain more bookings. United believes that the utility of these classes of information for passengers is low. United opposed the proposal to require submission of baggage handling data because it is not fairly comparable between carriers providing high levels of service and those providing no-frills service, and can mislead the public. In addition, United viewed information on misconnections and cabin facilities as not useful to consumers.

Delta Answer: Delta filed an answer to Continental's petition that opposed the proposed requirement for submission of data on telephone

reaction time. It supported the proposal that the Department require submission of data on baggage handling if such data can be filed and compared on a uniform basis.

TWA Answer: TWA agrees with requiring some performance reports if crafted to give only the most useful information to consumers. It favors reinstitution of the old Part 234, but expanded to include the top 300 markets, and prefers Unites's approach to reporting cancellations. TWA opposed requiring disclosure of information on telephone reservation response time and discount fare availability. TWA noted that consumers could rely on DOT's publication of consumer complaints for baggage handling information.

American Petition: American proposed that air carriers (exclusive of commuter carriers) would file monthly service quality data in standard format (old CAB Form 438) on computer tape, which could be consolidated and provided to consumers by the Department, the Airline Tariff Publishing Company or by CRS vendors through comparative service quality screen displays. In addition to the service quality factors suggested by Continental, American would have carriers include on the tape denied boarding statistics (involuntary bumpings only); data on misconnections, such as the percentage of passengers that failed to make connecting flights; amenities provided by air carriers to compensate passengers for delays due to misconnections; and cabin amenities and facilities, such as storage capacity for carry-on baggage, seat width and number of bathrooms. Telephone answering time data also would include a twelve month average.

In addition to these proposals a number of bills are currently pending in Congress that would require the Department to issue service quality reporting regulations.

The Department is requesting comment on whether consumers view problems with quality of service in these areas as significant enough to warrant regulatory action; what service elements are most important and whether data on any of these areas would be of real use to consumers.

The Department would require carriers to report monthly to the Department on various quality of service factors including baggage handling, telephone reservations answering response time, misconnections, denied boarding, and cabin amenities. One or more of the following five sections could be adopted if the Department issues a final rule in this area:

§ 234.___ Reservations answering time.

Each carrier shall report, on a monthly basis, for the previous month and for the previous 12 month period, the percentage of all telephone calls to its reservations department actually answered by a reservations agent within 20 seconds, and the average number of seconds, rounded to the nearest 1/10th, required for each call to be answered by a reservations agent.

§ 234.___ Denied boarding statistics.

Every carrier shall report, on a monthly basis, the information specified in Form 251. The reporting basis shall be all flights originating or terminating at, or serving, a point within the U.S. "Total Boardings" as used in the report shall include only passengers on flights for which confirmed reservations are offered. No reports need be filed for inbound international flights on which the protectons of Part 250 do not apply.

(If § 234.10 is adopted, conforming amendments to § 250.10 of the Department's Regulations, 14 CFR 250.10, and to Form 251 would be made.)

§ 234.___ Baggage handling statistics.

[For each flight segment operated], each carrier shall report, on a monthly basis, the total number of checked bags lost or involuntarily delayed, the total number of bags checked, and the percentage of bags neither lost nor involuntarily delayed, compared to total bags checked.

§ 234.___ Misconnected passengers.

Each carrier shall report, on a [monthly] basis, for each airport at which it operates more than [75] daily departures, the number of passengers who failed to make their intended online connections at such airport, and the total number of passengers who made online connections at such airport.

§ 234.___ Cabin configuration.

Each carrier shall report by aircraft type the amount of enclosed cubic feet of space available for stowage of carry-on articles that meet the requirements of FAR 25.787, divided by the number of seats available for sale on the aircraft. Each carrier shall also report the number of lavatories on each aircraft type, divided by the number of seats available for sale. Such a report shall be revised whenever the number of seats on each aircraft type is changed. Each carrier shall also describe its policies with respect to acceptance of carry-on baggage.

B. Questions

38. Is there any need for this type of disclosure? Do consumers view carrier performance in the areas covered by the proposed reporting requirements as significant elements of service competition? What elements are most important?

39. Should particular elements be added or deleted? What criteria or definitions should be used for each element? What triggers a report? What extenuating circumstances would apply for each element?

40. Who should receive, consolidate and disseminate this information to the public? The Department? Airline Tariff Publishing Co./The Official Airline Guide? CRS vendors on a separate display screen? What criteria should be used to identify poor service in each area? How should the information be consolidated in order to be most useful to consumers? By flight? In the aggregate (city-pair market, hub)? How should the information be disseminated?

41. Is comparative data needed for each element for effective quality of service advertising and competition? How can quality of service data be meaningfully compared among carriers given their different standards of service and equipment? How can we protect against manipulation of the data by carriers or vendors? What level of detail of information is necessary? Could a carrier effectively promote its own performance in these areas?

42. Is mandatory reporting the most efficient means to collect comparative data on each of the elements? Could comparative data on some elements be obtained by other means?

43. Should data reports on quality of service elements apply to all air carriers or just to scheduled passenger airlines? If small carriers are covered under this option, should they be allowed to file information on hard copy if they have no access to a computer?

44. Will more detailed regulations on reporting of any elements be required to ensure that statistics are reported in a uniform fashion, so that the information is not misleading and is useful to the public? What would be the costs of mandatory reporting and public dissemination?

45. What would be the costs of disseminating information on service quality factors? How can benefits be quantified?

46. What would be the effect in terms of increased quality-of-service competition?

C. Discount Fare Marketing Practices

ACAP Petition: ACAP proposed that the Department adopt a general rule that declares that it shall be an unfair or deceptive practice for any air carrier to

advertise the availability of seats at a specific fare, unless the carrier offers at least ten percent of the total number of seats available in a particular class of service on a given flight, or ten seats, whichever is greater, or it specifically discloses otherwise in its advertisements.

American Proposals: In its answer to ACAP's petition, American agreed that it would be reasonable to require carriers to offer not less than 10 percent of their weekly seats in each market on any particular capacity controlled fare, but does not support a direct, flight-by-flight intervention. It believes that ACAP's proposal would be tremendously burdensome and of little utility to consumers. It also believes that flight-by-flight disclosure of fare availability would discourage carriers from offering deeply discounted fares because such disclosure would give competitors highly sensitive information.

In its petition, American agreed that carriers should be required to disclose the proportion of total available seats offered at discount fares as of the time discount fares become unavailable, i.e., at the advance purchase cutoff date. This would minimize disclosure of competitively sensitive information. American opposed Continental's proposed required disclosure of demand levels, because it would not give consumers useful information on fare availability and could not be confirmed because Continental's proposal did not contain a reporting requirement.

Continental Petition: In response to the ACAP petition, Continental instead would require carriers to disclose in their advertisements the anticipated demand levels for discount fares (low, moderate, high) per market. It is unclear whether Continental would disclose absolute demand or demand relative to supply of discount seats.

United Answer: United opposed any regulation of airline advertising, because discount fares constantly change and would always be out of date, and because a particular carrier's mix of fares and its management of seat inventory are confidential and competitively sensitive information. It believes that existing laws and regulations are a much more effective weapon to use against bait and switch advertising.

Delta Answer: Delta opposes requiring that carriers disclose fare availability in advertising. It believes that the information would always be out of date and that existing consumer laws and regulations are adequate to address advertising problems.

The Department proposes to require air carriers to report monthly on the availability of seats offered at discount fares. If this proposal is adopted, the following section would be issued in a final rule:

§ 234.___ Discount fare seat availability.

Each carrier shall report, on a monthly basis, the percentage of its total seats offered at capacity controlled discount fares [for each flight segment] [operated in the previous month]. The percentage shall be calculated as follows:

The sum of (the number of capacity controlled passengers carried plus the number of unsold seats remaining when the discount fare becomes unavailable due to restrictions) divided by the total number of seats offered on the flight segment.

D. Questions

47. Is there any need for this type of disclosure? How frequently do carriers advertise fares that are not available?

48. If disclosure is required, should availability be expressed as a percentage? Should the advertisement reflect fare availability as of a certain date? Should availability be expressed as a function of high or low demand per flight, market, hub or system? What, if any, criteria should be used?

49. In view of the constantly changing nature of the information, is putting this information on a CRS display the only feasible way to update and transmit correct information to the travelling public? Would it be misleading if not in a computerized format?

50. Is this information so connected to price advertising as to be competitively sensitive? What would be the effect in terms of increased fare competition? What other competitive impacts is the availability of this information likely to have? Would a required minimum number of seats advertised at a particular fare discourage carriers from offering deep discount fares? Would disclosure of historic availability provide useful information to the public? Would it avoid alleged problems of reliability and competitive sensitivity?

51. How would this affect small carriers? What would be the costs of requiring disclosure of seat availability in advertising? Are there any costs associated with disseminating this information? What benefits would result? How can they be quantified? Do they outweigh the costs?

52. If there is a serious problem in this area, should the Department adopt ACAP's proposal and set minimum requirements for the number of seats that should be made available for discount fares on each flight? What would be the reference point for a ten percent/ten seat minimum? Should the requirement apply to each flight or each city-pair market?

IV. Non-Regulatory Alternatives

The Department also is considering a number of non-regulatory approaches to the scheduling and service quality information issues. Three options would require Congressional legislation and only could be implemented without additional authority. The three legislative options include two that involve FAA authority to impose or set standards for peak hour pricing and a third that would transfer DOT's consumer protection functions to the Federal Trade Commission (FTC), which has authority over such issues for non-regulated industries. Under the non-legislative option, the Department would encourage airport proprietors to impose peak hour pricing. The options available and questions on each follow.

A. Legislative Options

1. FAA Authority to Impose Peak-Hour Fees

Peak-hour pricing is a market-based means to allocate scarce airport and airway capacity at peak times of the day. In that it would attempt to minimize delays directly by reducing congestion, it addresses a somewhat different problem from some of the alternatives discussed above, which focus on mechanisms to encourage or require realistic scheduling. In theory, higher landing fees at peak hours will reduce the number of flights at those hours. Even if the carriers are able to pass the higher costs along to consumers by charging more for tickets on peak hour flights, price-sensitive consumers would be expected to switch to lower priced non-peak flights. This lower demand would lead carriers to reduce peak hour operations by shifting some flights to non-peak times. In cities served by more than one airport, carriers might shift some flights to the less congested facility.

There is currently no direct statutory authority under which the Department could assess such a fee, and it is arguably prohibited by section 45 of the Airline Deregulation Act of 1978, codified at 49 U.S.C. 334. One alternative would be for the Department to seek legislation to authorize the FAA to impose its own airtraffic-congestion user charges at selected times and selected airports.

Questions

53. Would peak hour pricing work to allocate scarce capacity at major hubs? How high would price differentials have

to be in order to shift flights to non-peak times?

54. What would be the most practical mechanism to allow the FAA to match shifting carrier demand with existing airport capacity?

55. If this alternative is pursued, should the legislation assign FAA congestion fee revenues for specific purposes (such as improvements at those airports), to the Aviation Trust Fund, for general FAA program funding, or for some other purpose?

56. How would this option impact smaller communities with less market demand?

57. The Department has long taken the position that airport operators are preempted from imposing restrictions on aircraft operations for the purpose of controlling airspace congestion. Would adoption of this approach be inconsistent with that policy, or could peak hour pricing of landing fees in these circumstances also be viewed as a mechanism to limit terminal and ground-side congestion, areas within the airport operators' purview? To the extent that adoption of this approach would be inconsistent with past policy, is such a policy change advisable, and how can the inconsistencies be minimized?

58. Many air carriers oppose peak hour pricing. It has been asserted that peak-hour pricing by airports could lead to serious confrontations between operators and their major customers—the air carriers. Are there viable mechanisms available to overcome these objections?

59. Because some airports are busy throughout the day, and thus have no off-peak hours, a fee might have to apply to the entire airport schedule to reduce overall demand. Other airports may reach similar all-day congestion levels in the next few years. How does this affect the viability of this alternative?

60. Should peak hour pricing be applied at the four airports covered by the Buy-Sell Rule, 14 CFR Part 93, Subpart S?

2. FAA Authority To Require Airports To Impose Peak-Hour User Fees

While similar to alternative 1 because of its reliance on peakhour pricing, this option differs because airports, rather than the FAA, would be implementing the program pursuant to standards established by the FAA. Airports currently charge landing fees to carriers (usually based on weight) to defray their operating costs. However, those airports that have received funds under the airport grant program are required to expend all airport revenues on airport-related expenses.

The legislation might authorize the FAA to condition federal airport grants or to adopt rules of general applicability. The FAA standards could specify that the surcharges could be spent on expansion of airport capacity or used to permit lower landing fees at uncongested hours. The lower fees might provide additional incentives to carriers to shift flights.

Questions

In addition to the questions on peak hour pricing listed under option IV.A.1, the Department solicits comments on the following:

61. To what extent do contractual agreements between airports and air carriers preclude the imposition of peak hour pricing?

62. How much of an administrative burden would fall on local airport operators collecting fees, once FAA established standards?

63. Could a national standard take into account differences among airports? How much discretion would be needed by local airport authorities to implement such a program? How can the program insure that the viability of the national transportation system is not impinged upon by such local control?

64. Should limits be placed on the collection and spending of peak-hour surcharges to ensure that the funds are spent to increase capacity or for other specified purposes?

3. Expansion of FTC Consumer Regulatory Authority To Include Aviation Matters

Through section 5 of the Federal Trade Commission Act (15 U.S.C. 41 *et seq.*), the FTC has consumer protection authority over most industries. This authority does not extend to air carriers and foreign air carriers subject to the Act, but otherwise is virtually identical to the Department's consumer responsibilities under section 411. It may be advisable to seek legislation that would extend the FTC's jurisdiction to cover airlines, and thereby give that agency concurrent consumer jurisdiction with the Department. At the time of the CAB sunset, the Department took the position that the FTC was the appropriate agency to have responsibility for consumer protection. This alternative would have the advantage of enabling the FTC to apply its consumer protection expertise to the aviation industry. Outright transfer of section 411 may not be advisable because continued Department involvement in some issues may be warranted—particularly with respect to international aviation, e.g., charter rules, international baggage rules, and other international consumer issues. On the other hand, it may be difficult to separate the FTC and DOT lines of responsibility. In addition, FTC rulemaking procedures are complex.

While the sharing of the aviation consumer functions might not affect delays directly, it is an option that is being considered by Congress. At least one bill now pending before Congress (S. 757) would create joint DOT/FTC jurisdiction over airline advertising. Because we are initiating this rulemaking, and to ensure that we consider all viable options, we seek comments on this alternative as well.

Questions

65. Should FTC have joint jurisdiction with the Department?

66. If FTC joint jurisdiction is established, how can it be structured to avoid regulatory duplication?

67. If FTC is given sole jurisdiction (e.g., through the complete transfer of section 411), should the law specify that FTC may use traditional rulemaking procedures, rather than FTC's current rulemaking process?

B. Non-Legislative Option

1. Department Initiative To Encourage Voluntary Peak-Hour Pricing

The Department is also soliciting comments on whether airports currently can implement peak hour pricing and whether the Department should encourage this practice on a voluntary basis. As with the other peak hour pricing alternatives, this alternative would seek to reduce delays from an operational standpoint, rather than assuring that carriers accurately advise the public of anticipated arrival and departure times.

Questions

In addition to the questions on peak hour pricing listed under options IV.A.1 and IV.A.2., the Department solicits comments on the following:

68. The Department has long taken the position that airport operators are preempted from imposing restrictions on aircraft operations for the purpose of controlling airspace congestion. Would adoption of this approach be inconsistent with that policy, or could peak hour pricing of landing fees in these circumstances also be viewed as a mechanism to limit terminal and ground-side congestion, areas within the airport operators' purview? To the extent that adoption of this approach would be inconsistent with past policy, is such a policy change advisable, and how can the inconsistencies be minimized?

69. Many air carriers oppose peak hour pricing. It has been asserted that peak-hour pricing by airports could lead to serious confrontations between operators and their major customers—the air carriers. Are there viable mechanisms available to overcome these objections?

70. Could airport operators implement the practice quickly on a wide scale? To what extent do airports have long term leases and contracts with carriers that might preclude implementation of peak hour pricing?

Review

Any rule promulgated as a result of this NPRM will be reviewed to determine its need and effectiveness after 2 years. Comments are requested on the proposed review.

Department Regulatory Policies and Procedures

The Department has considered the impacts of the proposals in this notice and determined that they are not major within the meaning of Executive Order 12291. The proposals are considered significant under DOT regulatory policies and procedures because of substantial public and Congressional interest and because they involve important Departmental policies. A draft regulatory evaluation has been prepared and placed in the rulemaking docket; a free copy may be obtained by contacting the Documentary Services Section at the address listed above.

The Department has also considered the economic impacts of these proposals for the purposes of the Regulatory Flexibility Act. I certify that none of the proposals would have a significant economic impact on a substantial number of small entities. Few of the affected certificated air carriers would qualify as small businesses within the meaning of the Act. The Department has, however, throughout this document sought specific comments on the effect of any action on smaller airlines and asked how any impact could be lessened.

The Department has concluded that none of these proposals would represent a major Federal Action having a significant impact on the environment under the National Environmental Policy Act.

Some of the proposed alternatives would impose information collection requirements that are subject to section 3504(h) of the Paperwork Reduction Act. We have submitted these requirements to the Office of Management and Budget for review and comment. Persons may submit comments on the collection-of-information requirements to OMB. Comments should be directed to Sam Fairchild, Office of Information and Regulatory Affairs, OMB, Washington, DC 20503. It would be appreciated if a copy of any comments sent to OMB is also sent to the DOT Docket 44327. If OMB approves the requirements, we will publish the approval numbers in the final document.

List of Subjects

14 CFR Part 234

Advertising, Air carriers, Consumer protection, Reporting requirements, Travel agents.

14 CFR Part 255

Advertising, Air carriers, Air transportation-foreign, Antitrust, Consumer protection, Essential air service, Travel agents.

Issued in Washington, D.C. on June 4, 1987.

Elizabeth Hanford Dole,

Secretary of Transportation.

The Proposed Rule

PART 234—AIRLINE SERVICE QUALITY PERFORMANCE REPORTS

1. The authority of the new Part 234 would be:

Authority: 49 U.S.C. 1302, 1324, 1374, 1375, 1377 and 1381; 5 U.S.C. 553(e) and 14 CFR 302.38.

2. In consideration of the previous discussion, it is proposed that a new Part 234 be added to 14 CFR. [Specific proposed rulemaking language is contained above in the preamble after discussion of each alternative.]

PART 255—CARRIER-OWNED COMPUTER RESERVATION SYSTEMS

1. The authority of Part 255 would be revised to read:

Authority: 49 U.S.C. 1302, 1324, 1374, 1381, 1389, and 1502.

§ 255.4 [Amended]

2. In consideration of the previous discussion, it is proposed that 14 CFR Part 255 be amended by adding a new paragraph (e) to § 255.4. [Specific proposed rulemaking language is contained in the preamble after the discussion of each alternative.]

[FR Doc. 87-13107 Filed 6-4-87; 4:53 pm]
BILLING CODE 4910-62-M

federal register

Wednesday
June 10, 1987

Part III

Department of Education

34 CFR Parts 785, 786, 787, 788, and 789
National Diffusion Network; Proposed Rulemaking
National Diffusion Network Program; Grants Availability; Notices

DEPARTMENT OF EDUCATION

34 CFR Parts 785, 786, 787, 788, and 789

National Diffusion Network

AGENCY: Department of Education.

ACTION: Notice of Proposed Rulemaking.

SUMMARY: The Secretary issues a notice of proposed rulemaking for the National Diffusion Network. These amendments are needed to implement amendments to the Education Consolidation and Improvement Act (ECIA) contained in the Higher Education Amendments of 1986, and to improve the operation of the National Diffusion Network.

DATES: Comments must be received on or before July 10, 1987.

ADDRESSES: All comments concerning these proposed regulations should be addressed to Lois N. Weinberg, U.S.Department of Eduation, Programs for the Improvement of Practice, Recognition Division, 555 New Jersey Avenue NW., Room 510, Washington D.C. 20208–1525.

A copy of any comments that concern information collection requirements should also be sent to the Office of Management and Budget at the address listed in the Paperwork Reduction Act section of this preamble.

FOR FURTHER INFORMATION CONTACT: Lois N. Weinberg, (202) 357–6134.

SUPPLEMENTARY INFORMATION: The National Diffusion Network (NDN) supports efforts to recognize and further excellence in education, including the nationwide dissemination of exemplary education programs. These programs have been developed at the local level by classroom teachers and other practitioners with funds provided by a variety of sources including school districts, private businesses and foundations, colleges and universities, State Education Agencies and Federal programs. After field testing and evaluation, again at the local level, these programs have been validated by the Department's Joint Dissemination Review Panel (JDRP) after review of the evidence of effectiveness presented by the programs' developers. Programs that have JDRP approval may compete for funding by the NDN to operate as Developer Demonstrator projects which disseminate exemplary education programs natiowide. The NDN also supports Dissemination Process projects which provide information, instructional materials and services nationwide that will be of use to education service providers.

The NDN also supports a State Facilitator project in each state. State Facilitators provide information to local school districts and other education service providers about the programs in the NDN, help them select programs that the appropriate to meet local needs, and assist in the process of installing selected programs in new sites.

Changes are proposed in the review process. The Department has in place a system to review the effectiveness of a program. The application process for securing funding from the NDN has carefully evaluated the dissemination strategies of a program. However, there has been no formal mechanism for determining whether a program's content in educationally significant or whether it is apporpriate for Federal dissemination. In addition, the Higher Education Amendments require that programs in the NDN reflect significant changes in practice and effectiveness.

Instead of JDRP review, a new concept of Dissemination Review Approval is proposed. Dissemination Review Approval would be based on a review and rating by two new panels, the Program Significance Panel (PSP) and the Program Effectiveness Panel (PEP).

The PSP would include a variety of individuals such as parents and representatives of the general public as well as teachers, principals, and curriculum and subject experts and other education practitioners. PSP members would not be Federal personnel. The PSP would first determine whether the program, product, practice or dissemination process is appropriate for dissemination through the NDN. In making this determination, the PSP considers whether the content of the program, product, practice or dissemination process would be generally acceptable to education service providers and parents. If the PSP determines that the program, product, practice or dissemination process is not appropriate for dissemination, the program, product, practice or dissemination process would receive no further review.

If the PSP determines that the program, product, practice or dissemination process is appropriate for dissemination, the PSP would then assign a score for significance based on the criteria in §§ 786.11 and 787.11. These criteria would include the need for the program, product or practice and whether the content of the program, product or practice is accurate and up-to-date.

The PEP would be similar to the JDRP. The panelists would be primarily evaluation experts. At least two-thirds of the panelists would not be Federal personnel. For a Developer Demonstrator project, the PEP would review the evidence of the effectiveness of a program, product or practice and assign a score based on the criteria in § 786.12. For a Dissemination Process project, the PEP would evaluate the procedures and criteria by which a Dissemination Process project determines the effectiveness of the information, instructional materials and services to be included in the dissemination activities and assign a score based on the criteria in § 787.12.

The PSP would review the actual training and classroom materials used by the programs, products, practices and dissemination processes to determine suitability for Federal recognition and degree of educational merit. The PEP would review the programs, products, practices and dissemination processes to determine if these programs actually achieve the results which the applicant for Dissemination Review Approval claims they achieve. In essence, the PSP looks to whether, assuming the project achieves what it sets out to achieve, the result would be beneficial to students. In contrast, the PEP addresses whether, on the basis of evaluation evidence, the project is in fact likely to achieve its goals.

Programs that have been determined by the Program Significance Panel to be appropriate for dissemination and have been assigned a score of at least 70 points out of the possible 100 points by the Program Effectiveness Panel would be given Dissemination Review Approval. Of the 70 points, at least 40 points must be for the criterion *"Results"* for Developer Demonstrators and at least 20 points must be for the criterion *"Results"* for Dissemination Processes. Neither panel would give Dissemination Review Approval independently of the other. Programs that have Dissemination Review Approval would be eligible to apply for Developer Demonstrator or Dissemination Process project grants from the NDN.

Programs that received JDRP approval before the Program Significance Panel is established would have to be reviewed by the PSP and receive a score which would be used as one of the funding considerations for a new grant award from the National Diffusion Network. Programs that were approved before the establishment of the PSP that have already received a Developer Demonstrator grant would not have to meet this requirement to receive a continuation award.

Dissemination Review Approval would last for six years. The previous requirement that programs be recertified

by the JDRP every four years would be dropped. After the six-year period, programs would be able to apply again for Dissemination Review Approval. However, after six years of NDN support, Developer Demonstrator projects would not be permitted to apply for additional funding, except in circumstances where the Secretary determines that it would be in the best interest of the government to allow additional Federal support.

A flow chart is attached at the end of this preamble that shows the steps involved in obtaining Dissemination Review Approval and NDN funding.

One special facilitator project would be established to provide to private schools nationwide the types of services that State Facilitators provide within a State. The purpose of the Private School Facilitator is to increase the use of exemplary education programs by private schools, whose participation to date in the National Diffusion Network has been limited. Although approximately 20 percent of all elementary and secondary schools are non-public, serving about ten percent of all elementary and secondary students, these schools account for less than 5 percent of adoptions of NDN programs during the past three years.

Dissemination Process projects would be established as a separate category of grant projects instead of as part of Developer Demonstrator projects. This change would make the description of requirements for selection procedures and operation of projects clearer and would improve project management and evaluation.

Selection criteria for new Dissemination Process projects and for the new Private School Facilitator project have been added. Selection criteria have been added to include the ratings of both the Program Significance Panel and the Program Effectiveness Panel in making funding decisions for Developer Demonstrator and Dissemination Process projects.

New categories would be added to the list of funding priorities for Developer Demonstrator and Dissemination Process projects to reflect the national interest in drop-out prevention programs, school-wide and district-wide school improvement programs and programs, that involve parents in the education of their children.

The lists of activities to be conducted by Developer Demonstrator and State Facilitator grantees would be revised. Several activities have been deleted and the descriptions of other activities have been clarified. In addition to the dissemination activities related to programs with JDRP approval and the proposed Dissemination Review Approval, State Facilitators and the Private School Facilitator would also disseminate information about the Education Resources Information Center (ERIC), the Department's Regional Labs and Centers, and the schools recognized through the Secretary's Recognition Program.

Support for the Secretary's School Recognition Program would be included as an activity of the National Diffusion Network. The purpose of the School Recognition Program is to identify effective schools and to make available their strategies to other schools. Schools considered for recognition are subject to careful review, including nomination by State Education Agencies, and site visits to selected schools. Although there have been informal linkages between what has been learned through the Recognition Program about effective practice and what is disseminated through the NDN, the Secretary now proposes to institutionalize the linkages between the two programs. One of the legislated purposes of the NDN is to "promote the utilization of the knowledge, talents and services of local staff associated with various educational excellence recognition efforts." As noted above, the School Recognition Program collects such information. This information about schools recognized by the Secretary would be disseminated through the NDN by the State and Private School Facilitators. Finally, the new priority for school-wide and district-wide improvement efforts has been added in anticipation that some recognized schools will apply as Developer Demonstrator projects. The Secretary's School Recognition Program would be operated directly by the Department and by contractors.

Requirements would be added to Developer Demonstrator projects' responsibilities, and included for Dissemination Process projects, concerning the use of disclaimers on printed materials. Projects would be required to include disclaimers indicating that the content of materials reproduced or disseminated with NDN support does not represent the policy of the Department. Projects would also be required to include a disclaimer indicating that if schools use Federal funds to adopt the project they must comply with section 439 of the General Education Provision Act (Student Rights in Research, Experimnenal Programs and Testing).

The Higher Education Amendments of 1986 specify that the post-secondary level is included in the National Diffusion Network. A careful review of the regulations currently in effect shows that the post-secondary level is already included in the current regulations in both the definitions of the education service providers who would use the NDN's programs and in the list of priority areas from which the Developer Demonsatrator projects are selected. These provisions related to postsecondary education would continue to be included.

The Secretary is reissuing the entire NDN regulations so that recent amendments to the NDN regulations published on August 14, 1986 in the **Federal Register** (51 FR 29190) and the amendments proposed here can be understood in contect. In addition; the regulations would be organized in five separate parts for clarity. Common elements would be included in a General Provisions section, and provisions implementing each of the different grant programs operated by the NDN would be contained in a separate part.

Executive Order 12291

These regulations have been reviewed in accordance with Executive Order 12291. They are not classified as major because they do not meet the criteria for major regulations established in the order.

Regulatory Flexibility Act Certification

The Secretary certifies that these proposed regulations would not have a significant economic impact on a substantial number of small entities. The addition of the Program Significance Panel would require that applicants submit curriculum and instructional material as part of the review process. However, this requirement would not be a great burden on applicants.

Paperwork Reduction Act of 1980

The following sections of the proposed regulations contain information collection requirements:

(a) *34 CFR Part 786;* 786.15, 786.20, 786.21. 786.22, 786.23, 786.24, 786.25, 786.26, and 786.27.

(b) *34 CFR Part 787:* 787.15, 787.20, 787.21, 787.22, 787.23, 787.24, 787.25, 787.26, and 787.27.

(c) *34 CFR Part 788:* 788.10, 788.21, 788.22, 788.23, 788.24, 788.25, 788.26, 788.27, 788.28, 788.29, 788.30, and 788.31.

(d) *34 CFR Part 789: 789.10, 789.20, 789.21, 789.22, 789.23, 789.24, 789.25, 789.26, 789.27, 789.28, 789.29, and 789.30.*

As required by section 3504(h) of the Paperwork Reduction Act of 1980, the Department of Education will submit a copy of these proposed regulations to the Office of Management and Budget

for its review. Organizations and individuals desiring to submit comments on the information collection requirements should direct them to the Office of Information and Regulatory Affairs, OMB, Room 3002, New Executive Office Building Washington, D.C. 20503; Attention: Joseph F. Lackey, Jr.

Intergovernmental Reviews

This program is subject to the requirements of Executive Order 12372 and the regulations in 34 CFR Part 79. The objective of the Executive Order is to foster an intergovernmental partnership and a strengthened federalism by relying on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

In accordance with the order, this document is intended to provide early notification of the Department's specific plans and actions for this program.

Invitation to Comment

Interested persons are invited to submit comments and recommendations regarding these proposed regulations.

All comments submitted in response to these proposed regulations will be available for public inspection, during and after the comment period, in Room 510F, 555 New Jersey Avenue N.W., Washington, D.C., between the hours of 8:30 a.m. and 4:00 p.m., Monday through Friday of each week except Federal holidays.

To assist the Department in complying with the specific requirements of Executive Order 12291 and the Paperwork Reduction Act of 1980 and their overall requirement of reducing regulatory burden, the Secretary invites comment on whether there may be further opportunities to reduce any regulatory burdens found in these proposed regulations.

Assessment of Educational Impact

The Secretary particularly requests comments on whether the regulations in this document would require transmission of information that is being gathered by or is available from any other agency or authority of the United States.

List of Subjects in 34 CFR Part 796

Dissemination, Education, Educational Research, Grant programs—education, Reporting and recordkeeping requirements.

(Catalog of Federal Domestic Assistance number 84.073—National Diffusion Network)

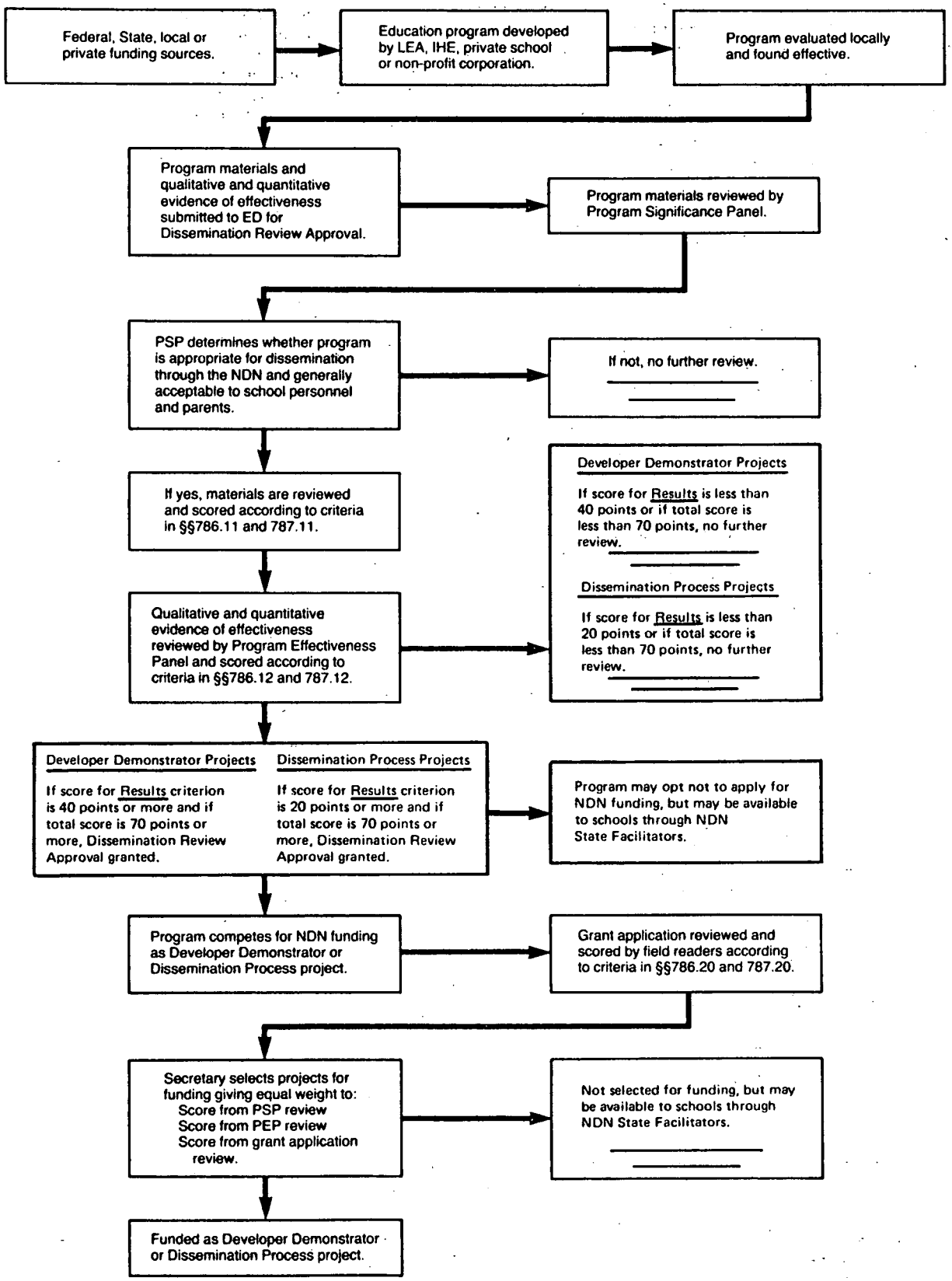
Dated: June 4, 1987.

William J. Bennett,

Secretary of Education.

BILLING CODE 4000-01-M

Dissemination Review Approval and National Diffusion Network Funding Process



BILLING CODE 4000-01-C

The Secretary proposes to amend Title 34 of the Code of Federal Regulations (CFR) by redesignating Part 796 as Part 785, revising redesignated Part 785 and adding new Parts 786, 787, 788 and 789, to read as follows:

PART 785—NATIONAL DIFFUSION NETWORK: GENERAL PROVISIONS

Subpart A—General

Sec.
785.1 What is the National Diffusion Network?
785.2 Who is eligible for an award?
785.3 What types of projects does the Secretary support?
785.4 What regulations apply?
785.5 What definitions apply?

Subpart B—[Reserved]

Subpart C—How Does the Secretary Make an Award?

785.20 How does the Secretary evaluate an application?

Subpart D—What Conditions Must Be Met After an Award?

785.30 What costs are not allowed?

Authority: 20 U.S.C. 3851, unless otherwise noted.

Subpart A—General

§ 785.1 What is the National Diffusion Network?

Under the National Diffusion Network (NDN), the Secretary supports activities designed to recognize and further excellence in education throughout the Nation.

(Authority: 20 U.S.C. 3851)

§ 785.2 Who is eligible for an award?

A public or nonprofit agency, organization, or institution that meets the appropriate qualifications in § 786.2, 787.2, 788.2 or 789.2 is eligible for an award under the National Network.

(Authority: 20 U.S.C. 3851)

§ 785.3. What types of projects does the Secretary support?

(a) Under the National Diffusion Network, the Secretary supports the following through grants and contracts:

(1) Developer Demonstrator Projects, as described in 34 CFR Part 786.

(2) Dissemination Process Projects, as described in 34 CFR Part 787.

(3) State Facilitator Projects, as described in 34 CFR Part 788.

(4) A Private School Facilitator Project as described in 34 CFR Part 789.

(b) Under the National Diffusion Network, the Secretary supports the following directly or through contracts:

(1) The Secretary's School Recognition Program.

(2) Technical assistance activities in support of projects under paragraph (a) of this section.

(Authority: 20 U.S.C. 3851)

§ 785.4 What regulations apply?

(a) *Grants.* The following regulations apply to grants under the National Diffusion Network:

(1) The Education Department General Administrative Regulations (EDGAR) In 34 CFR Part 74 (Administration of Grants), Part 75 (Direct Grant Programs—except § 75.650 (Participation of Students Enrolled in Private Schools)), Part 77 (Definitions that Apply to Department Regulations), Part 78 (Education Appeal Board), and Part 79 (Intergovernmental Review of Department of Education Programs and Activities).

(2) The regulations in Parts 785 through 789.

(b) *Contracts.* The following regulations apply to contracts under the National Diffusion Network:

(1) The Federal Acquistion Regulations in Title 48 of the Code of Federal Regulations.

(2) The regulations in Parts 785 through 789.

However, these regulations do not apply to contracts under § 785.3(b).

(Authority: 20 U.S.C. 3851)

§ 785.5 What definitions apply?

(a) *Definitions in EDGAR.* The following terms used in Parts 785, 786, 787, 788 and 789 are defined in 34 CFR 77.1

Applicant
Application
Award
Budget Period
Department
EDGAR
Equipment
Facilities
Grantee
Local educational agency (LEA)
Nonprofit
Project
Private
Public
State educational agency (SEA)

(Authority: 20 U.S.C. 3851)

(b) *Other definitions.* The following definitions also apply to Parts 785, 786, 787, 788 and 789:

"Adoption" means the use of an exemplary education program by an education service provider in a new setting.

"Adoption agreement" means an understanding among a Developer Demonstrator grantee, a State Facilitator grantee or the Private School Facilitator grantee and the officials of an education service provider concerning the responsibilities of each for the adoption of an exemplary education program.

"Certified demonstration site" means an adoption site that utilizes all key elements of an exemplary education program and is authorized by the exemplary education program sponsor to receive visitors and demonstrate the program.

"Certified trainer" means an individual authorized by an exemplary education program sponsor to perform certain functions such as awareness presentations, training and assistance in the adoption of an exemplary education program.

"Dissemination Review Approval" means that—

(1) A program has been determined to be appropriate for dissemination and reviewed and assigned a score by the Program Significance Panel according to the criteria in §§ 786.11 or 787.11; and

(2) The program has been reviewed and assigned a score by the Program Effectiveness Panel according to the criteria in §§ 786.12 or 787.12 and has received a score of at least 70 points.

"Education service provider" means any public or nonprofit private agency or organization responsible for the provision of education services, including State educational agencies (SEAs), local educational agencies (LEAs), nonprofit private educational agencies, public or nonprofit private institutions of higher education and other education-related agencies.

"ERIC" means the Educational Resources Information Center sponsored and supported by the Department of Education to disseminate education research results, practitioner-related materials and other resource information.

"Exemplary education program" means a program, product, practice or Dissemination Process which has Dissemination Review Approval.

"Local facilitator" means a member of the central administrative or supervisory staff of an education service provider or a designee who is committed to installing an NDN program and who will provide needed administrative and logistical support for installing the program.

"Program Effectiveness Panel" or "PEP" means a panel of experts, at least two-thirds of whom are not Federal employees, appointed by the Secretary, who review and assign scores to

programs according to the criteria in §§ 786.12 or 787.12.

"Program Significance Panel" or "PSP" means a panel of people knowledgeable about education, appointed by the Secretary, who are not employees of the Department of Education, and who review and rate the instructional and classroom materials used by programs in accordance with § § 786.11 or 787.11

"Regional Educational Laboratories" means regional laboratories funded by the Department to carry out applied educational research, development and related activities.

"Research and Development Centers" means centers funded by the Department to conduct educational research and development, and related activities.

Secretary's School Recognition Program" means a program operated by the Secretary to identify and recognize unusually effective public and private elementary and secondary schools, and schools that have been unsually successful in their responses to specific problems identified by the Secretary.

(Authority: 20 U.S.C. 3851)

Subpart B—[Reserved]

Subpart C—How does the Secretary Make an Award?

§ 785.20 How does the Secretary evaluate an application?

The Secretary evaluates an application—

(a) For a Developer Demonstrator grant on the basis of the criteria in Part 786;

(b) For a Dissemination Process grant on the basis of the criteria in Part 787;

(c) For a State Facilitator grant on the basis of the criteria in Part 788; and

(d) For a Private School Facilitator grant on the basis of the critiera in Part 789.

(Authority: 20 U.S.C. 3851)

Subpart D—What Conditions Must Be Met After an Award?

§ 785.30 What costs are not allowed?

In addition to costs not allowed under 34 CFR Parts 74 and 75, funds may not be used for stipends for educational personnel to participate in training activities, or for construction, repair, remodeling, or alteration of facilities or sites. See EDGAR Part 74, Subpart Q—Cost Principles.

(Authority: 20 U.S.C. 3851)

PART 786—NATIONAL DIFFUSION NETWORK: DEVELOPER DEMONSTRATOR PROJECTS

Subpart A—General

Sec.

Subpart B—How Does One Apply for an Award?

Subpart C—How Does the Secretary Make an Award?

Subpart D—What Conditions Must Be Met by the Recipient of an Award?

Authority: 20 U.S.C. 3851, unless otherwise noted.

Subpart A—General

§ 786.1 What is a Developer Demonstrator Project?

A Developer Demonstrator project must disseminate a specific exemplary education program nationwide.

(Authority: 20 U.S.C. 3851)

§ 786.2 Who is eligible for an award?

(a) *New awards.* (1) Any public or nonprofit private agency, organization or institution that has developed a program, product or practice that has Dissemination Review Approval and that is available to be visited may apply for a new Developer Demonstrator award.

(2) Notwithstanding 34 CFR 75.253, an otherwise eligible party that has received support for a specific Developer Demonstrator project for six years may not seek further funding under the National Diffusion Network unless the Secretary determines that it is in the best interest of the government to award funds for more than six years.

(3) Exemplary education programs developed with either Federal or non-Federal funds are eligible for NDN funding.

(b) *Continuation awards.* Any Developer Demonstrator grantee, otherwise eligible to apply for a continuation award, may apply for the continuation award even if either the Dissemination Review Approval period or the JDRP approval period has expired.

(Authority: 20 U.S.C. 3851)

§ 786.3 What priorities may the Secretary establish?

(a) (1) Each year the Secretary may announce in a notice published in the **Federal Register** the program priorities for which applicants may apply for assistance.

(2) The Secretary selects priorities under this section taking into account any unmet national needs.

(b) The Secretary may select priorities from the following subject areas or special needs:

(1) English, including literature.

(2) Science.

(3) History, geography, and civics, including special history programs in conjunction with the bicentennial of the Constitution of the United States.

(4) Mathematics or higher mathematics.

(5) Reading.

(6) Written or oral communications.

(7) Health, including drug abuse prevention programs.

(8) Ethics.

(9) The humanities.

(10) Programs that assist in improving school discipline and foster an atmosphere conducive to learning.

(11) Foreign languages.

(12) Computer science.

(13) Programs that advance students' educational and occupational goals, such as courses in the fine and performing arts, vocational education, and industrial arts.

(14) Programs that improve students' skills in comprehension, analysis, and

problem solving, including programs in philosophy.

(15) Programs that improve teaching and the quality of instruction.

(16) Educational leadership.

(17) School-wide and district-wide school improvement efforts.

(18) Drop-out prevention programs and programs for at risk students.

(19) Programs that foster parental involvement in schools.

(c) In addition to the priorities listed in paragraph (b) of this section, the Secretary may establish priorities as specified in one or both of the following paragraphs:

(1) The Secretary may establish priorities at specified instructional levels, such as preschool, elementary, secondary, postsecondary, or adult education.

(2) The Secretary may establish as a priority one or more of the following special populations:

(i) Gifted and talented students.

(ii) Socioeconomically disadvantaged students.

(iii) Limited English proficient students.

(iv) Handicapped students.

(v) Migrant students.

(vi) Functionally illiterate adults or adolescents.

(d) The Secretary may also limit a priority established under paragraph (b) of this section to—

(1) An instructional level;

(2) One or more of the special populations listed in paragraph (c)(2) of this section; or

(3) Both an instructional level and one or more of the special populations listed in paragraph (c)(2) of this section.

(Authority: 20 U.S.C. 3851)

§ 786.4 What regulations apply?

The following regulations apply to Developer Demonstrator projects:

(a) The regulations in 34 CFR Part 785.

(b) The regulations in this Part 786.

(Authority: 20 U.S.C. 3851)

Subpart B—How Does One Apply for an Award?

§ 786.10 What must an applicant submit for Dissemination Review Approval?

For Dissemination Review Approval of a program, product or practice, an applicant shall submit to the Secretary—

(a) Copies of all instructional, classroom and curriculum materials that are part of its program, product or practice; and

(b) Qualitative and quantitative evidence of the effectiveness of the program, product or practice.

(Authority: 20 U.S.C. 3851)

§ 786.11 How does the Program Significance Panel review a program, product or practice?

(a) The PSP determines whether or not a program, product or practice is appropriate for dissemination through the NDN. In making this determination, the PSP considers whether the content of the program, product or practice would be generally acceptable to education service providers and parents.

(b) If the PSP determines in accordance with paragraph (a) of this section that the program is not appropriate for dissemination through the NDN, no further review will be conducted by the PSP or the PEP.

(c) If the PSP determines in accordance with paragraph (a) of this section that a program, product or practice is appropriate for dissemination through the NDN, the PSP determines the extent to which the following criteria are met:

(1) *Need.* (25 points)

(i) There is an otherwise unmet need for the program, product or practice.

(ii) The needs the program, product or practice is designed to meet are important.

(2) *Content.* (50 points)

(i) The content of the program, product or practice is accurate and up-to-date;

(ii) The content of the program, product or practice is appropriate to the grade level or target audience.

(iii) The content of the program, product or practice is educationally sound.

(iv) The information is clearly presented in a manner that will be readily understood by teachers, students and parents.

(v) The intended outcomes of the program, product or practice are desired by education service providers.

(3) *Program design.* (25 points)

(i) The program design is an improvement over the design of other programs with similar intended outcomes.

(ii) The program design incorporates up-to-date standards for the field, subject area and population served.

(Authority: 20 U.S.C. 3851)

§ 786.12 How does the Program Effectiveness Panel review a program, product or practice?

(a) The PEP reviews each program, product or practice for educational effectiveness on the basis of the criteria in paragraph (d) of this section.

(b) The PEP awards up to 100 points for these criteria.

(c) The maximum score for each criterion is indicated in parentheses.

(d) In reviewing each program, product or practice the PEP determines the following:

(1) *Evaluation design.* (40 points) The PEP determines the extent to which the evaluation design—

(i) Is appropriate for the program, product or practice;

(ii) Is based on a correct interpretation of relevant research and literature;

(iii) Demonstrates that a clear and attributable connection exists between the evidence of an educational effect and the program treatment; and

(iv) Addresses rival hypotheses.

(2) *Results.* (50 points) The PEP determines the extent to which the results indicate—

(i) That the program, product or practice's effect is convincing relative to similar programs; and

(ii) The outcome claims of the program, product or practice are valid.

(3) *Replication.* (10 points) The PEP determines the extent to which the program, product or practice can be used at other sites with the likelihood of achieving similar results.

(Authority: 20 U.S.C. 3851)

§ 786.13 How is Dissemination Review Approval granted?

Dissemination Review Approval is granted if—

(a) The PSP finds that a program, product or practice is appropriate for dissemination by the NDN in accordance with § 786.11; and

(b) The PEP has given the program, products or practice a score of at least 40 points for the criterion in § 786.2(d)(2) *(Results)* and a total score of at least 70 points.

(Authority: 20 U.S.C. 3851)

§ 786.14 How long does Dissemination Review Approval last?

(a) Dissemination Review Approval remains in effect for six years after the date of approval.

(b) Approval granted by the Joint Dissemination Review Panel remains in effect for six years after the date of approval.

(Authority: 20 U.S.C. 3851)

§ 786.15 What activities must an applicant propose to carry out if it receives an award?

A Developer Demonstrator project must—

(a) Develop and provide materials for information about the exemplary education program and for training to install the program;

(b) Negotiate adoption agreements with State Facilitator grantees, the

Private School Facilitator grantee and education service providers;

(c) Assist those seeking to adopt the exemplary education program in new settings by providing training and technical assistance if requested by education service providers;

(d) Monitor and evaluate the quality, effectiveness and educational results of the adoptions;

(e) Maintain records during the grant period concerning the use of the exemplary education progam, including demographic and evaluation data;

(f) Develop and implement a system to identify and prepare Certified Trainers and Demonstration Sites;

(g) Participate with other NDN grantees in workshops and meetings arranged by the Secretary; and

(h) Cooperate with State Facilitator grantees and the Private School Facilitator grantee to carry out the activities in this section.

(Authority: 20 U.S.C. 3851)

Subpart C—How Does the Secretary Make an Award?

§ 786.20 How does the Secretary evaluate an application?

The Secretary evaluates an application according to the criteria in §§786.21 through 786.28.

(Authority: 20 U.S.C. 3851)

§ 786.21 Selection criterion—plan of operation. (25 points)

The Secretary reviews each application to determine the quality of the plan of operation for the project, including—

(a) The quality of the design of the project (See § 786.16 for a description of the activities that a Developer Demonstrator project must propose.);

(b) A description of training required to install the exemplary education program in new settings;

(c) The extent to which the plan of management is effective and ensures proper and efficient administration of the project;

(d) How well the objectives of the project relate to the purpose of the program;

(e) The quality of the applicant's plans to use its resources and personnel to achieve each objective; and

(f) If the applicant is an LEA or SEA, the quality of the applicant's plan to provide an opportunity for adoption of the exemplary education program by private schools in accordance with §786.31.

(Authority: 20 U.S.C. 3851)

§ 786.22 Selection criterion—quality of key personnel. (25 points)

(a) The Secretary reviews each application to determine the quality of key personnel the applicant plans to use on the project, including—

(1) The qualifications of the project director;

(2) The qualifications of each of the other key personnel to be used on the project;

(3) The time that each person referred to in paragraph (a)(1) and (2) of this section will commit to the project; and

(4) How the applicant, as part of its nondiscriminatory employment practices, will ensure that its personnel are selected for employment without regard to race, color, national origin, gender, age or handicapping condition.

(b) To determine the qualifications of personnel referred to in paragraphs (a)(1) and (2) of this section, the Secretary considers—

(1) Experience and training in fields related to the objectives of the project; and

(2) Any other qualifications that pertain to the quality of the project.

(Authority: 20 U.S.C. 3851)

§ 786.23 Selection criterion—budget and cost effectiveness. (5 points)

(a) The Secretary reviews each application to determine the extent to which—

(1) The budget is adequate to support the project; and

(2) Costs are reasonable in relation to the objectives of the project.

(b) The Secretary considers the extent to which—

(1) The costs to an adopter for installing the program in a new setting would be reasonable; and

(2) The projected number of educational service providers that would adopt the program each year is appropriate for the budget requested.

(Authority: 20 U.S.C. 3851)

§ 786.24 Selection criterion—evaluation plan. (20 points)

(a) The Secretary reviews each application to determine the quality of the evaluation plan for the project, including the extent to which the applicant's methods of evaluation—

(1) Are appropriate to the project; and

(2) To the extent possible, are objectives and produce data that are quantifiable.

(b) The Secretary reviews each applicant's plans for evaluating—

(1) The quality and effectiveness of informational materials, of training and follow-up, and of internal management plans; and

(2) The effectiveness of adoptions of the program, including impact on the students or the changes in teacher or administrator behavior.

Cross-reference. See 34 CFR 75.590 Evaluation by the grantee.

(Authority: 20 U.S.C. 3851)

§ 786.25 Selection criterion—adequacy of resources. (5 points)

The Secretary reviews each application to determine the adequacy of the resources that the applicant plans to devote to the project, including facilities, equipment and supplies.

(Authority: 20 U.S.C. 3851)

§ 786.26 Selection criterion—monitoring plan. (15 points)

The Secretary reviews each application to determine the extent to which the applicant clearly details plans for post-adoption monitoring of the implementation of the program and resulting benefits at the adoption sites.

(Authority: 20 U.S.C. 3851)

§ 786.27 Selection criterion—special dissemination strategies. (5 points)

The Secretary reviews each application to determine the extent to which the applicant proposes special dissemination strategies to meet specific characteristics of its program.

(Authority: 20 U.S.C. 3851)

§ 786.28 What additional criteria exist for new awards?

(a) In determining the order of selection under EDGAR § 75.217(d) for new Developer Demonstrator awards, the Secretary—

(1) Seeks diversity of projects funded under a particular competition or under this program;

(2) Gives equal weight to—

(i) The total rating under § 786.20;

(ii) The rating of the Program Significance Panel; and

(iii) The rating of the Program Effectiveness Panel; and

(3) For programs approved by the JDRP before the establishment of a scoring system, gives equal weight to—

(i) The total rating under § 786.20; and

(ii) The rating of the Program Significance Panel.

(b) Programs approved by the Joint Dissemination Review Panel whose approval period is still in effect must be reviewed by the Program Significance Panel according to the criteria in § 786.11 by July 1, 1988 in order to receive a new award.

(Authority: 20 U.S.C. 3851)

§ 786.29 What additional criteria exist for continuation awards?

In addition to the criteria for making a continuation award under 38 CFR 75.253, the Secretary may consider the effectiveness of the project during the previous budget period in determining the amount of funding for the next budget period.

(Authority: 20 U.S.C. 3851)

Subpart D—What Conditions Must be Met by the Recipient of an Award?

§ 786.30 What disclaimers are required on printed materials?

Developer Demonstrator projects must include disclaimers as follows on all instructional and curriculum materials reproduced or distributed with funds under this part—

(a) "The contents of this (insert type of publication; e.g., book, teacher's guide) were reproduced or are being distributed under a grant from the U.S. Department of Education. However, those contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the Federal Government;" and

(b) "If an education service provider uses funds under a program subject to Section 439 of the General Education Provisions Act (GEPA) (20 U.S.C. 1232h) to adopt this project, the education service provider must comply with Part 98 of Title 34 of the Code of Federal Regulations (Student Rights in Research, Experimental Programs and Testing) which contains the regulations implementing that section of GEPA."

(Authority: 20 U.S.C. 3851)

§ 786.31 What are a recipient's responsibilities for serving students enrolled in nonprofit private schools?

(a) *Responsibilities of LEAs and SEAs.* A grant to an LEA or SEA is subject to the requirements in Section 566 of the Education Consolidation and Improvement Act of 1981 concerning—

(1) Consultation with nonprofit private school officials in developing the application; and

(2) The opportunity for participation by nonprofit private school children. The requirements for consultation are governed by paragraph (b) of this section and 34 CFR 76.652.

(b) *Consultation.* (1) An applicant shall comply with paragraph (b)(2) of this section if the following conditions are met:

(i) The applicant is an LEA or SEA.

(ii) The applicant applies for a Developer Demonstrator award.

(iii) The project proposed under the application is designed for adoption at elementary or secondary schools.

(2) The applicant shall consult with officials of nonprofit private elementary and secondary schools to ensure that the project can benefit children in those schools.

(c) *Participation.* An LEA or SEA that receives a Developer Demonstrator award designed for adoption at elementary and secondary schools shall, based on the consultation under paragraph (b)(1) of this section, ensure that nonprofit private elementary and secondary schools have an opportunity to adopt the program.

(d) *Other requirements.* An LEA or SEA grantee shall comply with the rules for subgrantees in EDGAR § 76.658, Funds not to benefit a private school.

(Authority: 20 U.S.C. 3851, 3862)

PART 787—NATIONAL DIFFUSION NETWORK: DISSEMINATION PROCESS PROJECTS

Subpart A—General

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Subpart B—How Does One Apply for an Award?

Subpart C—How Does the Secretary Make an Award?

Subpart D—What Conditions Must be Met by the Recipient of an Award?

Authority: 20 U.S.C. 3851, unless otherwise noted.

Subpart A—General

§787.1 What is a Dissemination Process project?

A Dissemination Process project must provide information, instructional materials and services nationwide concerning specific content areas, bodies of research or fields of professional development, that will be of use to education service providers.

(Authority: 20 U.S.C. 3851)

§787.2 Who is eligible for an award?

Any public or nonprofit private agency, organization or institution that has in operation a dissemination process that has current Dissemination Review Approval may apply for a new Dissemination Process grant.

(Authority: 20 U.S.C. 3851)

§787.3 What priorities may the Secretary establish?

Each year the Secretary may announce in a notice published in the **Federal Register** the program priorities for which applicants may apply for assistance. The Secretary selects priorities in accordance with 34 CFR Part 786.3

(Authority: 20 U.S.C. 3851)

§787.4 What regulations apply?

The following regulations apply to Dissemination Process projects:

(a) The regulations in 34 CFR Part 785.

(b) The regulations in 34 CFR 786.3

(c) The regulations in this Part 787.

(Authority: 20 U.S.C. 3851)

Subpart B—How Does One Apply for an Award?

§787.10 What must an applicant submit for Dissemination Review Approval?

For Dissemination Review Approval of a dissemination process, an applicant shall submit to the Secretary—

(a) A description of its dissemination process;

(b) A description of the procedures and criteria for selecting information, instructional materials and services to be disseminated and for judging that they are educationally significant;

(c) A description of the procedures and criteria for evaluating qualitative and quantitative evidence of the

effectiveness of information, instructional materials and services to be disseminated;

(d) Samples of the information and instructional materials to be disseminated through the dissemination process; and

(e) Descriptions of the services to be provided through the dissemination process and of the methods for assuring broad dissemination.

§787.11 How does the Program Significance Panel review a Dissemination Process?

(a) The PSP determines whether or not the procedures and criteria for selecting information and instructional materials to be disseminated and for providing services ensure that the information and instructional materials are appropriate for dissemination through the NDN. In making this determination, the PSP considers whether the content of the information and instructional materials would be generally acceptable to education service providers and parents.

(b) If the PSP determines in accordance with paragraph (a) of this section, that the procedures and criteria for selecting information and instructional materials to be disseminated and for providing services do not ensure that the information and instructional materials are appropriate for dissemination through the NDN, no further review will be conducted by the PSP or the PEP.

(c) If the PSP determines in accordance with paragraph (a) of this section that the procedures examined produce information, instructional materials and services that are appropriate for dissemination by the NDN, the PSP determines the extent to which the dissemination process meets the following criteria:

(1) *Need.* (25 points)

(i) There is an otherwise unmet need for the information, instructional materials, and services.

(ii) The needs, the information, instructional materials and services are designed to meet are important.

(2) *Content.* (50 points)

(i) The content of the information, instructional materials and services is accurate and up-to-date.

(ii) The content of the information, instructional materials and services is appropriate to the grade level of target audience.

(iii) The content of the information and instructional materials is educationally sound.

(iv) The information, instructional materials, and services are clearly presented in a manner that will be readily understood by teachers, students and parents.

(v) The intended outcomes of the information, instructional materials and services are desirable.

(3) *Program design.* (25 points)

(i) The program design is an improvement over the design of other programs with similar intended outcomes.

(ii) The program design incorporates up-to-date standards for the field, subject area and population served.

(Authority: 20 U.S.C. 3851)

§ 786.12 How does the Program Effectiveness Panel review a Dissemination Process?

(a) The PEP reviews each dissemination process for educational effectiveness by examining the procedures and criteria for selecting information and instructional materials to be disseminated and for providing services according to the criteria in paragraph (d) of this section.

(b) The PEP awards up to 100 points for these criteria.

(c) The maximum score for each criterion is indicated in parentheses.

(d) In reviewing each dissemination process the PEP determines the following:

(1) *Evaluation design.* (50 points) The PEP determines the extent to which the evaluation design—

(i) Is appropriate for the program;

(ii) Is based on correct interpretation of relevant research and literature;

(iii) Demonstrates that a clear and attributable connection exists between the evidence of an educational effect and the program treatment; and

(iv) Addresses rival hypotheses.

(2) *Results.* (25 points) The PEP determines the extent to which the results indicate that the process is particularly effective relative to similar processes.

(3) *Replication.* (25 points) The PEP determines the extent to which the information, instructional materials and services can be used at other sites with the likelihood of achieving similar results.

(Authority: 20 U.S.C. 3851)

§ 787.13 How is Dissemination Review Approval granted?

Dissemination Review Approval is granted if—

(a) The PSP finds that the procedures and criteria for selecting information and instructional materials to be disseminated and for providing services will ensure that they are appropriate for dissemination by the NDN in accordance with § 787.11; and

(b) The PEP has given the procedures and criteria a score of at least 20 points for the criterion in § 787.12(d)(2) *(Results)* and a total score of at least 70 points.

(Authority: 20 U.S.C. 3851)

§ 787.14 How long does Dissemination Review Approval last?

(a) Dissemination Review Approval remains in effect for six years after the date of approval.

(b) Approval granted by the Joint Dissemination Review Panel remains in effect for six years after the date of approval.

(Authority: 20 U.S.C. 3851)

§ 787.15 What activities must an applicant propose to carry out if it receives an award?

A Dissemination Process project must—

(a) Develop and provide upon request of an education service provider, descriptions of the information, material and services concerning the content areas, fields of professional development or bodies of research that are available through the dissemination process, for education service providers throughout the Nation to use in becoming familiar with the grantee's project;

(b) Provide upon request the information, material and services described in paragraph (a) of this section;

(c) Provide, if appropriate, training in support of the use of the information, materials and services provided;

(d) Evaluate the quality and effectiveness of the dissemination process as specified in the evaluation design for the project;

(e) Maintain records during the grant period concerning the dissemination of information and materials, and the provision of services;

(f) Monitor and evaluate the extent of use by teachers and students and the educational results obtained through use of the information, materials and services selected by education service providers;

(g) Participate with other NDN grantees in workshops and meetings arranged by the Secretary; and

(h) Cooperate with State Facilitator grantees and the Private School Facilitator project to carry out the activities in this section.

(Authority: 20 U.S.C. 3851)

Subpart C—How Does the Secretary Make an Award?

§ 787.20 How does the Secretary evaluate an application?

The Secretary evaluates an application according to the criteria in § 787.21 through 787.28.

(Authority: 20 U.S.C. 3851)

§ 787.21 Selection criterion—plan of operation. (30 points)

The Secretary reviews each application to determine the quality of the plan of operation for the project, including—

(a) The quality of the design of the project (See § 787.16 for a description of the activities that a Dissemination Process project must propose.);

(b) A clear description of the information and instructional materials to be disseminated, and the services to be provided;

(c) A description of any training to education service providers the program might offer, if appropriate, in support of the use of the materials or information described above;

(d) The extent to which the plan of management is effective and ensures proper and efficient administration of the project;

(e) How well the objectives of the project relate to the purpose of the program;

(f) The quality of the applicant's plans to use its resources and personnel to achieve each objective;

(g) If the applicant is an LEA or SEA, the quality of the applicant's plans to provide an opportunity for private schools to use the information, instructional materials and services.

(Authority: 20 U.S.C. 3851)

§ 787.22 Selection criterion—quality of key personnel. (10 points)

(a) The Secretary reviews each application to determine the quality of key personnel the applicant plans to use on the project, including—

(1) The qualifications of the project director;

(2) The qualifications of each of the other key personnel to be used in the project;

(3) The time that each person referred to in paragraphs (a) (1) and (2) of this section plans to commit to the project; and

(4) How the applicant, as part of its nondiscriminatory employment practices, will ensure that its personnel are selected for employment without regard to race, color, national origin, gender, age or handicapping condition.

(b) To determine the qualifications of personnel referred to under paragraphs (a) (1) and (2) of this section, the Secretary considers—

(1) Experience and training in fields related to the objectives of the project; and

(2) Any other qualifications that pertain to the quality of the project.

(Authority: 20 U.S.C. 3851)

§ 787.23 Selection criterion—budget and cost effectiveness. (10 points)

The Secretary reviews each application to determine the extent to which—

(a) The budget is adequate to support the project; and

(b) Costs are reasonable in relation to the objectives of the project;

(c) The estimated cost to the adopter for purchasing or using the materials, information or services that are available through the Dissemination Process is reasonable.

(Authority: 20 U.S.C. 3851)

§ 787.24 Selection criterion—evaluation plan. (15 points)

The Secretary reviews each application to determine the quality of the evaluation plan for the project, including the extent to which the applicant's methods of evaluation—

(a) Are appropriate for the project;

(b) To the extent possible, are objective and produce data that are quantifiable; and

(c) Are appropriate to evaluate—

(1) The quality and effectiveness of informational materials, of any training provided and follow-up, and of internal management plans; and

(2) The use and effectiveness of the materials and information provided to education service providers.

(Authority: 20 U.S.C. 3851)

§ 787.25 Selection criterion—adequacy of resources. (10 points)

The Secretary reviews each application to determine the adequacy of the resources that the applicant plans to devote to the project, including facilities, equipment, and supplies.

(Authority: 20 U.S.C. 3851)

§ 787.26 Selection criterion—monitoring plan. (5 points)

The Secretary reviews each application to determine the extent to which the applicant clearly details plans that show promise of effective management of the project, including monitoring the use of materials and information provided through the Dissemination Process, and resulting benefits to educational service providers.

(Authority: 20 U.S.C. 3851)

§ 787.27 Selection criterion—special dissemination strategies. (20 points)

The Secretary looks for information that shows the extent to which the applicant proposes special dissemination strategies to meet specific characteristics of its program.

(Authority: 20 U.S.C. 3851)

§ 787.28 What additional criteria exist for new awards?

(a) In determining the order of selection under EDGAR § 75.217(d) for new Dissemination Process awards, the Secretary—

(1) Seeks diversity of projects funded under a particular competition or under this program; and

(2) Gives equal weight to—

(i) The total rating under § 787.20;

(ii) The rating of the Program Significance Panel; and

(iii) The rating of the Program Effectiveness Panel.

(b) Programs approved by the Joint Dissemination Review Panel whose approval period is still in effect must be reviewed by the Program Significance Panel according to the criteria in § 787.11 by July 1, 1988 in order to receive a new award.

(Authority: 20 U.S.C. 3851)

§ 787.29 What additional criteria exist for continuation awards?

If the Secretary makes a continuation award under § 75.253, the Secretary may consider the effectiveness of the project during the previous budget period in determining the amount of funding for the next budget period.

(Authority: 20 U.S.C. 3851)

Subpart D—What Conditions Must be Met by the Recipient of an Award?

§ 787.30 What disclaimers are required on printed materials?

Dissemination Process projects must include disclaimers as follows on all instructional and curriculum materials reproduced or distributed with funds under this part:

(a) "The contents of this (insert type of publication; e.g., book, teacher's guide) were reproduced or are being distributed under grant from the U.S. Department of Education. However, those contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the Federal Government;" and

(b) "If an education service provider uses funds under a program subject to Section 439 of the General Education Provisions Act (GEPA) (20 U.S.C. 1232h) to pay for information, instructional

materials or services provided by this project, the education service provider must comply with Part 98 of Title 34 of the Code of Federal Regulations (Student Rights in Research, Experimental Programs and Testing) which contains the regulations implementing that section of GEPA."

(Authority: 20 U.S.C. 3851)

§ 787.31 What are a recipient's responsibilities for serving students enrolled in nonprofit private schools?

(a) *Responsibilities of LEAs and SEAs.* A grant to an LEA or SEA is subject to the requirements in Section 586 of the Education Consolidation and Improvement Act of 1981 concerning—

(1) Consultation with nonprofit private school officials in developing the application; and

(2) The opportunity for participation by nonprofit private school children. The requirements for consultation are governed by paragraph (b) of this section and 34 CFR 76.652 of EDGAR.

(b) *Consultation.* (1) An applicant shall comply with paragraph (b)(2) of this section if the following conditions are met:

(i) The applicant is an LEA or SEA;

(ii) The applicant applies for a Dissemination Process award;

(iii) The information, materials and services to be provided through the dissemination process would be used in elementary or secondary schools.

(2) The applicant shall consult with officials of nonprofit private elementary and secondary schools to ensure that the project can benefit children in those schools.

(c) *Participation.* An LEA or SEA that receives a Dissemination Process award designed to provide information, materials and services to elementary and secondary schools shall, based on the consultation under paragraph (b)(1) of this section, ensure that nonprofit elementary and secondary schools have an opportunity to use the information, instructional materials and services.

(d) *Other requirements.* An LEA or SEA grantee shall comply with the rules for subgrantees in EDGAR § 76.658, Funds not to benefit a private school.

(Authority: 20 U.S.C. 3851, 3862)

PART 788—NATIONAL DIFFUSION NETWORK: STATE FACILITATOR PROJECTS

Subpart A—General

Sec.

Authority: 20 U.S.C. 3851, unless otherwise noted.

Subpart A—General

§ 788.1 What is a State Facilitator Project?

A State Facilitator Project must disseminate a wide variety of exemplary education programs within the particular State served by each project.

(Authority: 20 U.S.C. 3851)

§ 788.2 Who is eligible for an award?

Any public or nonprofit private agency, organization, or institution located in the State to be served may apply for a State Facilitator award.

(Authority: 20 U.S.C. 3851)

§ 788.3 What regulations apply?

The following regulations apply to State Facilitator projects:

(a) The regulations in 34 CFR Part 785.

(b) The regulations in this Part 788.

(Authority: 20 U.S.C. 3851)

Subpart B—How Does One Apply for an Award?

§ 788.10 What activities must an applicant propose to carry out if it receives an award?

A State Facilitator project must—

(a) Inform public and private education service providers about the availability of all exemplary education programs in the National Diffusion Network;

(b) Assist education service providers to select exemplary education programs to meet their needs;

(c) Negotiate adoption agreements with Developer Demonstrator and Dissemination Process grantees and education service providers;

(d) Arrange for Developer Demonstrator and Dissemination Process grantees to provide training and follow-up services when requested by education service providers;

(e) Arrange for the selection and training of Local Facilitators;

(f) Assist in the identification and preparation of Certified Trainers and Demonstration Sites;

(g) Maintain records during the grant period concerning the exemplary education programs adopted in the State, including demographic data and program retention rates;

(h) Monitor and evaluate the activities of the State Facilitator project;

(i) Participate with other NDN grantees in workshops and meetings arranged by the Secretary;

(j) Cooperate with Developer Demonstrator grantees, Dissemination Process grantees and the Private School Facilitator grantee to carry out the activities in this section; and

(k) Disseminate information about ERIC, Research and Development Centers and Regional Educational Laboratories, and schools recognized through the Secretary's School Recognition Program.

(Authority: 20 U.S.C. 3851)

Subpart C—How Does the Secretary Make an Award?

§ 788.20 How many awards does the Secretary make in each State?

The Secretary makes one award in each State

(Authority: 20 U.S.C. 3851)

§ 788.21 How does the Secretary evaluate an application?

The Secretary evaluates an application according to the criteria in §§ 788.22 through 788.32.

(Authority: 20 U.S.C. 3851)

§ 788.22 Selection criterion—plan of operation. (15 points)

The Secretary reviews each application to determine the quality of the plan of operation for the project, including,—

(a) The quality of the design of the project (See § 788.10 for a description of

the activities that a State Facilitator must propose.);

(b) The extent to which the plan of management is effective and ensures proper and efficient administration of the project;

(c) How well the objectives of the project relate to the purpose of the program;

(d) The quality of the applicant's plans to use its resources and personnel to achieve each objective;

(e) If the applicant is an LEA or SEA, the quality of the applicant's plans to provide an opportunity for participation of private schools in accordance with § 788.40.

(Authority: 20 U.S.C. 3851)

§ 788.23 Selection criterion—quality of key personnel. (20 points)

(a) The Secretary reviews each application to determine the quality of key personnel the applicant plans to use on the project, including—

(1) The qualifications of the project director;

(2) The qualifications of each of the other key personnel to be used in the project;

(3) The time that each person referred to in paragraph (a) of this section will commit to the project; and

(4) The extent to which the applicant, as part of its nondiscriminatory employment practices, will ensure that its personnel are selected for employment without regard to race, color, national origin, gender, age or handicapping condition.

(b) To determine the qualifications of personnel referred to in paragraphs (a)(1) and (2) of this section, the Secretary considers—

(1) Experience and training in fields related to the objectives of the project; and

(2) Any other qualifications that pertain to the quality of the project.

(Authority: 20 U.S.C. 3851)

§ 788.24 Selection criterion—budget and cost effectiveness. (5 points)

The Secretary reviews each application to determine the extent to which—

(a) The budget is adequate to support the project; and

(b) Costs are reasonable in relation to the objectives of the project.

(Authority: 20 U.S.C. 3851)

§ 788.25 Selection criterion—evaluation plan. (10 points)

The Secretary reviews each application to determine the quality of the evaluation plan for the project, including the extent to which the applicant's methods of evaluation—

(a) Are appropriate to the project; and

(b) To the extent possible, are objective and produce data that are quantifiable.

Cross-reference. See 34 CFR 75.590 Evaluation by the grantee.

(Authority: 20 U.S.C. 3851)

§ 788.26 Selection criterion—adequacy of resources. (5 points)

The Secretary reviews each application to determine the adequacy of the resources that the applicant plans to devote to the project, including facilities, equipment and supplies.

(Authority: 20 U.S.C. 3851)

§ 788.27 Selection criterion—monitoring plan. (15 points)

The Secretary reviews each application to determine the extent to which the applicant clearly details plans to monitor and assist sites that adopt the programs, and provide follow-up services after training.

(Authority: 20 U.S.C. 3851)

§ 788.27 Selection criterion—consultation during application. (5 points)

The Secretary reviews each application to determine the extent to which the applicant, in developing its application, has consulted with the SEA, LEAs, Institutions of Higher Education, private schools and other educational service providers in the State to be served.

(Authority: 20 U.S.C. 3851)

§ 788.27 Selection criterion—consultation and participation during project. (5 points)

The Secretary reviews each application to determine the extent to which the applicant, in carrying out the project activities, provides for consultation with, and participation of the SEA, LEAs, Institutions of Higher Eduation, private schools and other education service providers in the State.

(Authority: 20 U.S.C. 3851)

§ 788.30 Selection criterion—innovative dissemination strategies. (10 points)

The Secretary reviews each application to determine the extent to which the applicant proposes innovative dissemination strategies.

(Authority: 20 U.S.C. 3851)

§ 788.31 Selection criterion—provision of information about other programs. (10 points)

Take Secretary reviews each application to determine the extent to which the applicant has the capacity to provide information about ERIC, Research and Development Centers and Regional Educational Laboratories, and schools recognized through the Secretary's School Recognition Program to educational personnel throughout the State.

(Authority: 20 U.S.C. 3851)

§ 788.32 What additional criteria exist for continuation awards?

If the Secretary makes a continuation award under § 75.253, the Secretary may consider the effectiveness of the project during the previous budget period in determining the amount of funding for the next budget period.

(Authority: 20 U.S.C. 3851)

Subpart D—What Conditions Must be Met by the Recipient of an Award?

§ 788.40 What are a recipient's responsibilities to students enrolled in nonprofit private schools?

(a) *Responsibilities of LEAs and SEAs.* A grant to an LEA or SEA is subject to the requirements in § 586 of the Education Consolidation and Improvement Act of 1981 concerning—

(1) Consultation with nonprofit private school officials in developing the application; and

(2) The opportunity for participation by nonprofit private school children. The requirements for consultation are governed by paragraph (b) of this section and § 76.652 of EDGAR.

(b) *Consultation.* (1) An applicant shall comply with paragraph (b)(2) of this section if the following conditions are met:

(i) The applicant is an LEA or SEA.

(ii) The applicant applies for a State Facilitator award.

(2) The applicant shall consult with officials of nonprofit private elementary and secondary schools in the State served by the project to determine appropriate strategies to ensure that children in those schools can benefit from the project.

(c) *Participation.* An LEA or SEA that receives a State Facilitator grant shall use the strategies developed under paragraph (b)(1) of this section to ensure that teachers and administrators from nonprofit private elementary and secondary schools have an opportunity to participate.

(d) *Other requirements.* An LEA or SEA grantee shall comply with the rules for subgrantees in EDGAR § 76.658, Funds not to benefit a private school.

(Authority: 20 U.S.C. 3851, 3862)

PART 789—NATIONAL DIFFUSION NETWORK: PRIVATE SCHOOL FACILITATOR PROJECT

Subpart A—General

Sec.

Subpart B—How Does One Apply for an Award?

Subpart C—How Does the Secretary Make an Award?

Authority: 20 U.S.C. 3851, unless otherwise noted.

Subpart A—General

§ 789.1 What is a Private School Facilitator Project?

A Private School Facilitator project must disseminate exemplary education programs to private schools nationwide.

(Authority: 20 U.S.C. 3851)

§ 789.2 Who is eligible for an award?

Any public or nonprofit private agency, organization, or institution may apply for a Private School Facilitator grant to serve private schools nationwide.

(Authority: 20 U.S.C. 3851)

§ 789.3 What regulations apply?

The following regulations apply to the Private School Facilitator project:

(a) The regulations in 34 CFR Part 785.

(b) The regulations in this Part 789.

(Authority: 20 U.S.C. 3851)

Subpart B—How Does One Apply for an Award?

§ 789.10 What activities must an applicant propose to carry out if it receives an award?

The Private School Facilitator project must—

(a) Inform private schools throughout the Nation about the availability of exemplary education programs in the National Diffusion Network;

(b) Assist private education service providers to select exemplary education programs to meet their needs;

(c) Negotiate adoption agreements with Developer Demonstrator and Dissemination Process grantees and private education service providers;

(d) Arrange for Developer Demonstrator and Dissemination Process grantees to provide information, training and follow-up services to staff members of private schools if requested;

(e) Arrange for the selection and training of local facilitators;

(f) Assist in the identification and training of Certified Trainers;

(g) Maintain records during thr grant period concerning the exemplary education programs adopted by private schools, including demographic data and program retention rates;

(h) Monitor and evaluate the activities of the Private School Facilitator project;

(i) Participate with other NDN grantees in workshops and meetings arranged by the Secretary;

(j) Cooperate with Developer Demonstrator grantees, Dissemination Process grantees and State Facilitator grantees in establishing linkages to private schools throughout the Nation; and

(k) Disseminate information about ERIC, Research and Development Centers and Regional Educational Laboratories, and schools recognized through the Secretary's School Recognition Program.

(Authority: 20 U.S.C. 3851)

Subpart C—How Does the Secretary Make an Award?

§ 789.20 How does the Secretary evaluate an application?

The Secretary evaluates an application for a Private School Facilitator award according to the criteria in §§ 789.21 through 789.30.

(Authority: 20 U.S.C. 3851)

§ 789.21 Selection criterion—plan of operation. (15 points)

The Secretary reviews each application to determine the quality of the plan of operation for the project, including—

(a) The quality of the design of the project (See § 789.10 for a description of each of the activities that the Private School Facilitator must propose.);

The extent to which the plan of management is effective and ensures proper and efficient administration of the project;

(c) How well the objectives of the project relate to the purpose of the program;

(d) The quality of the applicant's plans to use its resources and personnel to achieve each objective; and

(e) The extent to which the applicant clearly details plans to monitor and assist sites that adopt programs, and provide follow-up services after training.

(Authority: 20 U.S.C. 3851)

§ 789.22 Selection criterion—quality of key personnel. (10 points)

(a) The Secretary reviews each application to determine the quality of key personnel the applicant plans to use on the project, including—

(1) The qualifications of the project director;

(2) The qualifications of each of the other key personnel to be used in the project;

(3) The time that each person referred to in paragraphs (a)(1) and (2) of this section will commit to the project; and

(4) The extent to which the applicant, as part of its nondiscriminatory employment practices, will ensure that its personnel are selected for employment without regard to race, color, national origin, gender, age or handicapping condition.

(b) To determine qualifications of personnel referred to under paragraphs (a)(1) and (2) of this section, the Secretary considers—

(1) Experience and training in fields related to the objectives of the project; and

(2) Any other qualifications that pertain to the quality of the project.

(Authority: 20 U.S.C. 3851)

§ 789.23 Selection criterion—budget and cost effectiveness. (10 points)

The Secretary reviews each application to determine the extent to which—

(a) The budget is adequate to support the project and is cost effective; and

(b) Costs are reasonable in relation to the objectives of the project.

(Authority: 20 U.S.C. 3851)

§ 789.24 Selection criterion—evaluation plan. (10 points)

The Secretary reviews each application to determine the quality of

the evaluation plan for the project, including the extent to which—

(a) The applicant's methods of evaluation—

(1) Are appropriate for the project; and

(2) To the extent possible, are objective and produce data that are quantifiable, including evaluation of the impact of the adoptions in private schools; and

(b) The applicant will seek the assistance of national experts and professional associations concerned with private schools in designing and carrying out evaluation activities.

Cross-reference. See 34 CFR 75.590 Evaluation by the grantee.

(Authority: 20 U.S.C. 3851)

§ 789.25 Selection criterion—adequacy of resources. (5 points)

The Secretary reviews each application to determine the adequacy of the resources that the applicant plans to devote to the project, including facilities, equipment and supplies.

(Authority: 20 U.S.C. 3851)

§ 789.26 Selection criterion—consultation during application. (5 points)

The Secretary reviews each application to determine the extent to which the applicant, in developing its application, has consulted with diverse private school educators.

(Authority: 20 U.S.C. 3851)

§ 789.27 Selection criterion—consultation and participation during project. (5 points)

The Secretary reviews each application to determine the extent to which the applicant, in carrying out project activities, provides for consultation with, and participation of diverse private school educators.

(Authority: 20 U.S.C. 3851)

§ 789.28 Selection criterion—innovative dissemination strategies. (10 points)

The Secretary reviews each application to determine the extent to which the applicant proposes innovative dissemination strategies.

(Authority: 20 U.S.C. 3851)

§ 789.29 Selection criterion—previous experience. (20 points)

The Secretary reviews each application to determine the extent to which the applicant has had previous experience in successfully working with and providing services to many different types of private schools nationwide.

(Authority: 20 U.S.C. 3851)

§ 789.30 Selection criterion—provision of information about other programs. (10 points)

The Secretary reviews each application to determine the extent to which the applicant has the capacity to provide information about ERIC, Research and Development Centers and Regional Educational Laboratories, and schools recognized through the Secretary's School Recognition Program.

(Authority: 20 U.S.C. 3851)

§ 789.31 What additional criteria exist for continuation awards?

If the Secretary makes a continuation award under §75.253, the Secretary may consider the effectiveness of the project during the previous budget period in determining the amount of funding for the next budget period.

(Authority: 20 U.S.C. 3851)

[FR Doc. 87-13108 Filed 6-9-87; 8:45am]

BILLING CODE 4000-01-M

DEPARTMENT OF EDUCATION

[CFDA No.: 84.073A]

Notice Inviting Applications for new Developer Demonstrator Awards Under the National Diffusion Network Program for Fiscal Year 1987

PURPOSE: Provides grants for the nationwide dissemination of exemplary education programs.

PRIORITIES: *Absolute priorities.* Taking into account unmet national needs, the Secretary has selected absolute priorities for this competition from the list of priorities in § 786.3. (See the Notice of Proposed Rulemaking for the National Diffusion Network published in this issue of the **Federal Register.**) Only applications for projects in these priority areas will be considered. The Secretary seeks applications for projects in the following priority areas:

1. English, including literature.
2. Science.
3. History, geography and civics, including special history programs in conjunction with the bicentennial of the Constitution of the United States.
4. Mathematics.
5. Reading for the secondary level, and adult literacy programs.
6. Written communications.
7. Health, including drug abuse prevention programs.
8. The humanities.
9. Programs that assist in improving school discipline and that foster an atmosphere conducive to learning.
10. Foreign languages.
11. Programs that improve students' skills in comprehension, analysis, and problem solving, including programs in philosophy.
12. Programs that improve teaching and the quality of instruction.
13. Educational leadership.
14. School-wide and district-wide improvement efforts.
15. Drop-out prevention programs and programs for at-risk youth.
16. Programs that foster parental involvement in schools.
17. Early childhood.
18. Gifted and talented students.

However, this listing of priorities does not bind the Department of Education to a specific number of projects in each priority, or to selecting projects for funding in every priority.

Invitational Priority. The Secretary particularly invites applications for projects that have not been funded previously under the National Diffusion Network. However, these applications will not receive an absolute or competitive advantage over other applications.

DEADLINE FOR TRANSMITTAL OF APPLICATIONS: *July 15, 1987.*

DEADLINE FOR INTERGOVERNMENTAL REVIEW COMMENTS: *September 15, 1987.*

APPLICATIONS AVAILABLE: *June 15, 1987.*

AVAILABLE FUNDS: $480,000.

ESTIMATED RANGE OF AWARDS: $40,000 to $75,000.

ESTIMATED AVERAGE SIZE OF AWARDS: $52,000.

ESTIMATED NUMBER OF AWARDS: 7 to 10.

PROJECT PERIOD: 24–48 months.

APPLICABLE REGULATIONS: (a) Regulations governing the National Diffusion Network as proposed to be codified in 34 CFR Parts 785 and 786. (Applications are being accepted based on the Notice of Proposed Rulemaking which is published in this issue of the **Federal Register.** If any substantive changes are made in the final regulations for this program, applicants will be given the opportunity to revise or resubmit their applications); and

(b) the Education Department General Administrative Regulations, 34 CFR Parts 74, 75, 77, 78, and 79.

FOR APPLICATIONS OR INFORMATION CONTACT: Mrs. Anne Barnes, U.S. Department of Education, Recognition Division, 555 New Jersey Avenue, NW., Room 510, Washington, DC. 20208. Telephone: (202) 357–6157.

Program Authority: 20 U.S.C. 3851.

Dated: June 4, 1987.

Chester E. Finn, Jr.,

Assistant Secretary and Counselor to the Secretary.

[FR Doc. 87–13111 Filed 6–9–87; 8:45 am]

BILLING CODE 4000–01–M

[CFDA No.: 84.073E]

Notice Inviting Applications for new Dissemination Process Project Awards Under the National Diffusion Network Program for Fiscal Year 1987

PURPOSE: Provides grants for the nationwide operation of Dissemination Process projects.

PRIORITIES: *Absolute Priorities. Taking into account unmet national needs, the Secretary has selected absolute priorities for this competition from the list of priorities in § 786.3. (See the Notice of Proposed Rulemaking for the National Diffusion Network published in this issue of the* **Federal Register.**) Only applications for projects in these priority areas will be considered. The Secretary seeks applications for projects in the following priority areas:

1. Science.
2. History, geography and civics, including special history programs in conjunction with the bicentennial of the Constitution of the United States.
3. Mathematics.
4. Health, including drug abuse prevention programs.
5. The humanities.
6. Programs that assist in improving school discipline and foster an atmosphere conducive to learning.
7. Programs that improve teaching and the quality of instruction.
8. Drop-out prevention programs and programs for at-risk youth.

However, this listing of priorities does not bind the Department of Education to a specific number of projects in each priority, or to selecting projects for funding in every priority.

DEADLINE FOR TRANSMITTAL OF APPLICATIONS: July 15, 1987.

DEADLINE FOR INTERGOVERNMENTAL REVIEW COMMENTS: *September 15, 1987.*

APPLICATIONS AVAILABLE: *June 15, 1987.*

AVAILABLE FUNDS: Up to $220,000.

ESTIMATED RANGE OF AWARDS: $50,000 to $125,000.

ESTIMATED AVERAGE SIZE OF AWARDS: $73,000.

ESTIMATED NUMBER OF AWARDS: 3.

PROJECT PERIOD: The Secretary expects to make awards for project periods of up to 48 months.

APPLICABLE REGULATIONS: (a) Regulations governing the National Diffusion Network as proposed to be codified in 34 CFR Parts 785, 786, and 787. (Applications are being accepted based on the Notice of Proposed Rulemaking which is published in this issue of the **Federal Register.** If any substantive changes are made in the final regulations for this program, applicants will be given the opportunity to revise or resubmit their applications); and

(b) the Education Department General Administrative Regulations, 34 CFR Parts 74, 75, 77, 78, and 79.

FOR APPLICATIONS OR INFORMATION CONTACT: Ms. Margaret E. McNeely, U.S. Department of Education, Recognition Division, 555 New Jersey Avenue, NW., Room 510, Washington, DC 20208. Telephone: (202) 357–6134.

Program authority: 20 U.S.C. 3851.

Dated: June 4, 1987.

Chester E. Finn, Jr.,

Assistant Secretary and Counselor to the Secretary.

[FR Doc. 87–13109 Filed 6–9–87; 8:45 am]

BILLING CODE 4000–01–M

[CFDA No.: 84.073F]

Notice Inviting Applications for a New Private School Facilitator Award Under the National Diffusion Network Program for Fiscal Year 1987

Purpose: Provides a grant for the nationwide dissemination to private schools to exemplary education programs.

Deadline for Transmittal of Applications: July 23, 1987.

Deadline for Intergovernmental Review Comments: September 23, 1987.

Applications Available: June 15, 1987.

Available Funds: Up to $225,000.

Estimated Range of Award: $150,000 to $225,000.

Estimated Number of Awards: 1 (one).

Project Period: The Secretary expects to make the award for a project period of up to 48 months.

Applicable Regulations: (a) Regulations governing the National Diffusion Network as proposed to be codified in 34 CFR Parts 785 and 789. (Applications are being accepted based on the Notice of Proposed Rulemaking which is published in this issue of the **Federal Register.** If any substantive changes are made in the final regulations for this program, applicants will be given the opportunity to revise or resubmit their applications); and

(b) The Education Department General Administrative Regulations, 34 CFR Parts 74, 75, 77, 78, and 79.

For Applications or Information Contact: Ms. Lois N. Weinberg, U.S. Department of Education, Recognition Division, 555 New Jersey Avenue, NW., Room 510, Washington, DC 20208. Telephone: (202) 357–6147.

Program Authority: 20 U.S.C. 3851.

Dated: June 4, 1987.

Chester E. Finn, Jr.,

Assistant Secretary and Counselor to the Secretary.

[FR Doc. 87–13110 Filed 6–9–87; 8:45 am]

BILLING CODE 4000–01–M

Federal Register

Wednesday
June 10, 1987

Part IV

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405, 412, 413, and 466

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1988 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 412, 413, and 466

[BERC-400-P]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1988 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare inpatient hospital prospective payment system to implement necessary changes arising from legislation and our continuing experience with the system. One of these changes is the inclusion in the prospective payment system of hospitals located in Puerto Rico.

In addition, in the addendum to this proposed rule, we are proposing changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. These changes would be applicable to discharges occurring on or after October 1, 1987. We are also setting forth proposed rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system.

DATE: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on August 10, 1987.

ADDRESS: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-400-P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland

In commenting, please refer to file code BERC-400-P. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT: Linda Magno, (301) 594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), enacted by the Social Security Amendments of 1983 (Pub. L. 98-21) on April 21, 1983, a system for payment of inpatient hospital services under Medicare Part A (Hospital Insurance) based on prospectively-set rates was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the inpatient hospital prospective payment system are located in 42 CFR Part 412.

Sections 1886(d)(1) (A), (C), and (D) of the Act provide for the implementation of the prospective payment system over a four-year transition period. During the transition period, payment to hospitals is based on a combination of the Federal prospective payment rates and hospital-specific rates, the proportions of which change with the hospital's cost reporting period. In addition, during that period, the Federal rate is a combination of regional and national rates, the proportions of which change with the Federal fiscal year.

On September 3, 1986, we published a final rule (51 FR 31454) to implement the fourth year of the transition period (that is, Federal fiscal year (FY) 1987). Technical corrections to that final rule were issued on October 1, 1986 (51 FR 34980). However, on October 21, 1986, the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509) was enacted. Portions of sections 9302 and 9303 of Pub. L. 99-509 made several amendments to section 1886 of the Act that affect Medicare payments to hospitals in FY 1987. On November 24, 1986, we published a final rule with comment period (51 FR 42229) to implement these statutory changes as follows:

- For FY 1987, a 1.15 percent increase in the Federal rates effective with discharges occurring on or after October 1, 1986 and before October 1, 1987; a 1.15 percent increase in the hospital-specific rates effective for cost reporting periods beginning during FY 1987; and a 1.15 percent increase in the target rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system.
- Reductions in the standardized amounts to reflect differences in the proportions of payments for outliers between urban and rural hospitals.
- Revised rural referral center criteria.
- Reductions in payments for capital-related costs.

The comment period for the November 24, 1986 final rule ended on January 23, 1987. We are in the process of developing a **Federal Register** document to deal with suggestions from the public concerning regional criteria for rural referral centers.

B. Major Contents of This Proposed Rule

This proposed rule would be effective for the fifth year of operation of the prospective payment system. Following is a summary of the major changes that we are proposing to make to the system:

1. Changes to DRG Classification and Weighting Factors

We are proposing to restructure the alcohol and drug abuse DRGs. In addition, as required by section 1886(d)(4)(C) of the Act, as amended by section 9302(e)(1) of Pub. L. 99-509, we must adjust the DRG weighting factors for discharges in FY 1988. Our proposed changes are set forth in section II of this preamble.

2. Revision of Wage Index Methodology

We are proposing to change the methodology we use for computing the national average hourly wage that serves as the basis for indexing the area wage levels. We are also proposing to update the wage index. Our proposal is discussed in section III of this preamble.

3. Inclusion of Puerto Rican Hospitals in the Prospective Payment System

Under the authority of section 1886(d)(9)(A) of the Act, which was added by section 9304(a) of Pub. L. 99-509, inpatient hospital services furnished by hospitals located in Puerto Rico are to be paid for under the prospective payment system beginning with discharges on or after October 1, 1987. Our proposed implementation of this expansion of the prospective payment system is discussed in section IV of this preamble.

4. Other Decisions and Regulations Changes

In section V of this preamble, we discuss several current provisions of the regulations in 42 CFR Parts 405, 412, 413, and 466 not discussed elsewhere in this rule, and set forth certain proposed changes concerning—

- Review of DRG assignments;
- An increase in the prospective payment rates and rate-of-increase limits;
- Payment for outlier costs;
- Payments to sole community hospitals;
- Referral center criteria and basis of payment; and
- Payment for services of nonphysician anesthetists.

5. Determining Prospective Payment Rates and Rate-of-Increase Limits

In the addendum to this proposed rule, we set forth proposed changes to the methods, amounts, and factors for determining the FY 1988 prospective payment rates. We are also proposing new target rate percentages for determining the rate-of-increase limits for FY 1988 for hospitals and hospital units excluded from the prospective payment system.

6. Impact Analysis

In Appendix A, we set forth an analysis of the impact that the proposed changes described in this rule would have on affected entities.

7. Report to Congress on the Update Factor

Section 1886(e)(3)(B) of the Act, as amended by section 9302(e)(3) of Pub. L. 99–509, requires the Secretary to report to Congress no later than April 1, 1987 on our initial estimate of an update factor for FY 1988 for both prospective payment hospitals and hospitals excluded from the prospective payment system. This report is included as Appendix B of this proposed rule.

8. Discussion of Prospective Payment Assessment Commission Recommendations

The Prospective Payment Assessment Commission (ProPAC) is directed by section 1886(d)(4)(D) of the Act to make recommendations to the Secretary with respect to adjustments to the DRG classification and weighting factors and to report to Congress with respect to its evaluation of any adjustments made by the Secretary. ProPAC is also directed, by the provisions of sections 1886 (e)(2) and (e)(3) of the Act, to make recommendations to the Secretary on the appropriate percentage change factor to be used in updating the average standardized amounts beginning with FY 1986 and thereafter. These recommendations were submitted to the Secretary on April 1, 1987.

We are printing ProPAC's report, which includes its recommendations, as Appendix C of this document. The recommendations, and the actions we are proposing to take with regard to them (when an action is recommended), are discussed in detail in the appropriate sections of this preamble. Those recommendations that are not specifically relevant to matters presented below are discussed in section VI of this preamble. For a brief summary of the ProPAC recommendations, we refer the reader to pages 6 through 10 of the ProPAC report as set forth in Appendix C of this proposed rule.

II. Proposed Changes to DRG Classifications and Weighting Factors

A. Background

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's average payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for a case in that particular DRG relative to the national average of resources consumed per case. Thus, cases in a DRG with a weight of 2.0 would, on average, require twice as many resources as the average case.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act, as originally added to the Act by Pub. L. 98–21, required that the Secretary adjust the DRG classifications and weighting factors effective for discharges occurring in FY 1986 and at least every four fiscal years thereafter. These adjustments were to be made to reflect changes in resource consumption, treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

Therefore, on September 3, 1985, as a part of the FY 1986 prospective payment final rule, we published in the **Federal Register** (50 FR 35722) revised DRG weights that were recalibrated to reflect changes in resource consumption that had occurred subsequent to 1981 (the base-year from which data were used to derive the initial DRG weights). Unlike the FY 1984 (48 FR 39876) and FY 1985 (49 FR 34780) DRG weights, which were largely developed from 1981 Medicare hospital cost report data and billing records from a 20 percent sample of Medicare beneficiaries (the MEDPAR file), the DRG weights set forth in the September 3, 1985 final rule were constructed from the FY 1984 Part A Tape Bill (PATBILL) file, which is the universe of available inpatient bills for Medicare patients discharged in 1984.

We decided not to recalibrate the DRG weights for discharges occurring in FY 1987, but announced our intention to recalibrate DRG weights annually thereafter. For a detailed explanation of that decision, we refer the reader to the discussion in the June 3, 1986 proposed rule (51 FR 20032) and the September 3, 1986 final rule (51 FR 31527). We did, however, make several revisions to the DRG classification system for discharges occurring in FY 1987. These revisions were discussed in a final notice issued on June 3, 1986 (51 FR 20192) and in the September 3, 1986 final rule (51 FR 31476).

Section 9302(e) of Pub. L. 99–509 revised section 1886(d)(4)(C) of the Act to require that we adjust the DRG classifications and weighting factors annually beginning with discharges occurring in FY 1988. Most of the proposed changes to the DRG classification system that would be effective for discharges occurring in FY 1988 are discussed in a separate notice published in the **Federal Register** on May 19, 1987 (52 FR 18877). However, as a part of this proposed rule, we are addressing two of the reclassification issues; that is, the alcohol and drug abuse DRGs and surgical hierarchies. We would also recalibrate the DRG weights as discussed below. In addition, we are proposing to revise § 412.60(d), which describes how often we revise the DRG classification and weighting factors, so that it conforms to the law as amended by Pub. L. 99–509.

B. Reclassification of Alcohol and Drug Abuse DRGs

In the January 3, 1984 final rule on the prospective payment system, we excluded alcohol/drug treatment hospitals and units from the prospective payment system in response to criticism we received concerning the alcohol and drug abuse DRGs (49 FR 241). In that document, we specified that the exclusion would be permitted only until October 1, 1985, and that after that date we intended to include an adjustment to the DRG classification system that would permit prospective payment to be made appropriately for alcohol and drug treatment services.

In the June 10, 1985 proposed rule, the alcohol and drug abuse DRGs were restructured and redefined and we proposed to end the exclusion for alcohol/drug hospitals and units effective with cost reporting periods beginning on or after October 1, 1985.

The revised factors were based on charge data for 42,264 cases in the FY 1984 PATBILL file. We again received a large number of public comments on this proposal, most of which urged us to continue the exclusion of alcohol and drug hospitals and units because the restructured DRGs needed further refinement. In response to these comments, in the September 3, 1985 final rule, we extended the alcohol/drug exclusion another year (through cost reporting periods beginning before October 1, 1986) for hospitals and units that were already excluded. That final rule stated that we would continue our efforts in resolving the concerns of the public and developing improved alcohol and drug abuse DRGs classification as soon as possible (50 FR 35669). In the September 3, 1986 final rule, we extended the exclusion of alcohol/drug hospitals and units another year (that is, through cost reporting periods beginning before October 1, 1987) because the analysis of alcohol and drug abuse cases we had undertaken was not yet complete (51 FR 31469).

The existing configuration of the alcohol and drug abuse DRGs, Major Diagnostic Category (MDC) 20, is as follows:

- DRG 433—Alcohol/Drug Use and Induced Organic Mental Disorders, Left AMA.
- DRG 434—Alcohol/Drug Abuse, Intoxication, Induced Mental Syndrome Except Dependence and/or Other Symptomatic Treatment.
- DRG 435—Alcohol/Drug Dependence, Detoxification and/or Other Symptomatic Treatment.
- DRG 436—Alcohol/Drug Dependence with Rehabilitation Therapy.
- DRG 437—Alcohol/Drug Dependence, Combined Rehabilitation and Detoxification Therapy.

The criticism of the current structure of the alcohol and drug abuse DRGs stemmed from concern that the lengths of stay for each DRG do not reflect treatment patterns in the alcohol/drug treatment community and from questions about the data on which the DRG weights were based, since coding of detoxification and rehabilitation was not specifically required until billing instructions were issued in May 1984.

In order to analyze this criticism about deficiencies in the analysis conducted and the data employed in the FY 1986 reclassification of the alcohol and drug abuse DRGs, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) undertook to reabstract and augment data from a representative sampling of the MDC 20 cases treated in FY 1984 for which Medicare payment was made. (The FY 1986 reclassification was based on data from FY 1984.) The data gathering and analysis took place between March and December 1986 and the study was carried out by ADAMHA in concert with the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Office of the Assistant Secretary for Planning and Evaluation, and HCFA.

The collection and abstraction of data took place between March and July of 1986. A stratified random sample of 849 hospitals was drawn nationwide. All Medicare alcohol and drug admissions for FY 1984 (about 15,000) were identified in these hospitals. Hospitals were asked to pull the medical records for each of these patients and to send in copies of the face sheet and discharge summaries from the records. These data were reviewed, abstracted, and merged to create the data base for the analysis. The resulting data base consists of the chosen items abstracted from the medical records and data contained in the Medicare bill files. Nearly 90 percent of all hospitals responded and almost 80 percent of the beneficiaries selected were included in the final analysis.

Among the specific industry concerns that were addressed in the study were the following:

- The structure and weighting of the detoxification and/or symptomatic treatment DRGs were reviewed.
- The structure and weighting of the rehabilitation (and combined rehabilitation and detoxification) DRGs were reviewed.
- New variables including age, disability status, and polysubstance use were coded, analyzed, and evaluated for incorporation in the MDC 20 structure.
- The presence or absence of non-MDC 20 comorbidity was analyzed to determine the impact on DRGs in MDC 20.

The following are the findings of ADAMHA based on its reabstraction study:

- Significant problems, due to poor reporting and definitional issues, were evidenced in the billing data employed by HCFA to establish the original (1984) and the revised (1985) MDC 20 DRGs and their weights.
- Analysis predicated upon the reabstracted data suggests the need to restructure the MDC 20 DRGs using variables not currently included.
- A number of individuals leave treatment before treatment is complete; however, their reimbursement is not adjusted to reflect significantly shorter lengths of stay.
- The existing structure of DRGs 434 and 435 does little to differentiate patient resource consumption or length of stay.
- Not all variables identified by commenters significantly improve the variance between or the homogeneity within DRGs in MDC 20.
- Age, polysubstance abuse, and type of drug abused other than alcohol were analyzed and found not to be major predictors of resource consumption in the Medicare population.
- Non-MDC 20 comorbidity is a significant factor in the cost of treating patients that receive detoxification and/or symptomatic treatment services (current DRGs 434, 435, and 437).
- Analysis predicated on the reabstracted data suggests the need to recalculate the weights in MDC 20.

HCFA staff conducted independent analyses of the ADAMHA study data. We took the data from about 12,000 cases for which ADAMHA had obtained responses and dropped those cases from psychiatric and rehabilitation hospitals and units, which, because they are statutorily excluded from the prospective payment system, are excluded from our recalibration file. This process yielded 9,659 reabstracted cases for analysis from short-stay hospitals, alcohol hospitals, and alcohol units for analysis.

We weighted the study cases to the recalibration universe by DRG and type of provider Weighting was done in this manner so that the influence of alcohol hospitals and units on the mean charges and length of stay by DRG would not be diluted. While short-stay hospitals contributed 95 percent of all alcohol cases in the recalibration file, they contributed less than 75 percent of DRG 436 cases and only 65 percent of DRG 437 cases.

We looked at the effect of the record reabstraction on the distribution and composition of the alcohol and drug abuse DRGs. The reabstracted records were grouped in two ways—the standard methodology using principal diagnosis and up to four secondary diagnoses, and an alternative methodology that involved switching the principal diagnosis, when coded V5781 (rehabilitation) with the first-listed secondary diagnosis in order to avoid having those cases (501 study cases) move from the alcohol/drug DRGs (MDC 20) to the general rehabilitation DRG (462). The choice between these two methods for regrouping the cases did not significantly affect the mean charges or length of stay by DRG or the distribution of cases among the five alcohol DRGs.

We examined the effect of splitting each of the alcohol and drug abuse DRGs on the basis of presence or absence of complications or comorbidities. Since the vast majority of alcohol and drug cases in each DRG show a complication or comorbidity related to alcohol or drug use, the presence or absence of such represented a virtually meaningless distinction.

However, when we examined the effect of presence or absence of non-MDC 20 complications or comorbidities, the homogeneity of resource use of DRGs 434 and 435 improves noticeably when these two DRGs are split into pairs with and without complications or comorbidities. A similar result is found with respect to homogeneity of length of stay for DRGs 434 and 435. The same effect is not seen with the other DRGs.

We also tested the effect of combining DRGs 434 and 435 and then splitting the collapsed group based on presence or absence of non-MDC 20 complications or comorbidities. The revised groups are more homogeneous in terms of resource use than the original DRGs 434 and 435, and only slightly less homogeneous in the aggregate than the separate pairs of 434 and 435 (with or without complications or comorbidities).

We repeated all of the above analyses on FY 1985 and FY 1986 discharges currently available in the MEDPAR file. We found that the distribution of alcohol and drug abuse cases across the alcohol/drug DRGs in FYs 1985 and 1986 is much more comparable to the distribution from the weighted ADAMHA study cases after reabstraction then to the original recalibration file. Moreover, the percentage of cases in DRGs 434–437 with either a detoxification or a rehabilitation code has risen significantly, from 11 percent in the FY 1984 recalibration file to 70 percent in the FY 1986 MEDPAR file. This finding suggests that coding of alcohol and drug abuse cases has improved considerably since FY 1984.

Based on these analyses, we found that the following proposed restructuring of MDC 20 would improve homogeneity of the alcohol and drug abuse DRGs in terms of resource intensity and length of stay:

DRG 433—Alcohol/Drug Abuse or Dependence, Left AMA

DRG 434—Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment, with Complication or Comorbidity (C.C.)

DRG 435—Alcohol/Drug Abuse or Dependence, Detoxification or Other Symptomatic Treatment, without C.C.

DRG 436—Alcohol/Drug Dependence with Rehabilitation

DRG 437—Alcohol/Drug Dependence with Detoxification and Rehabilitation.

We are proposing to implement this new classification of the DRGs within MDC 20 effective for discharges occurring on or after October 1, 1987. Alcohol/drug hospitals and units that are currently excluded would be included in the prospective payment system beginning with the first day of a hospital's or unit's cost reporting period that begins on or after October 1, 1987.

Under the DRGs currently in effect, only those cases in MDC 20 with a principal diagnosis of alcohol/drug dependence can be assigned to DRGs 436 and 437 because patients without a principal diagnosis of dependence were not thought to require inpatient hospital rehabilitation. In addition, cases with a principal diagnosis of alcohol amnestic syndrome (code 291.1), other alcoholic dementia (code 291.2), alcohol withdrawal hallucinosis (code 291.3), other specified alcoholic psychosis (code 291.8), or unspecified alcoholic psychosis (code 291.9) cannot currently be assigned to DRGs 436 and 437 because patients with these diagnoses were considered unable to benefit from alcohol/drug rehabilitation while in a psychotic state.

Both the ADAMHA study data and our FY 1985 and FY 1986 bill files indicate that some patients with these principal diagnoses (assigned to current DRGs 434 or 435, as appropriate) have, in fact, been receiving rehabilitation. In addition, we have been advised that if hallucinosis (291.3) or psychosis (291.8 and 291.9) is brought under control or alcohol amnestic syndrome (291.1) is at least partially reversed, or if there is some relevant residual mental functioning despite the presence of alcohol dementia (291.2), these patients may be able to benefit from rehabilitation. For these reasons, we are proposing that cases coded 291.1, 291.2, 291.3, 291.8, and 291.9, whether these are principal or secondary diagnoses, be permitted in DRGs 436 and 437 if it is the physician's judgment that a patient with these codes may benefit from rehabilitation and rehabilitation is furnished and reported on the bill submitted. We intend to monitor these cases carefully.

In addition, we are proposing that cases with a secondary diagnosis of alcohol or drug dependence be permitted to group to DRGs 436 and 437 if their principal diagnosis is also in MDC 20. We are proposing this change in light of our findings (which are generally consistent across both FY 1985 and FY 1986 bill files) that patients who have diagnoses of alcohol/drug dependence and receive rehabilitation have comparable resource consumption whether alcohol/drug dependence is a principal or secondary diagnosis.

Among the cases in the current DRGs 434 and 435, both before and after taking into account the proposed changes to DRGs 436 and 437, we found no statistically significant differences in mean charges or length of stay between abuse cases (from DRG 434) and dependence cases (from DRG 435), whether we compare all cases, cases with detoxification, cases with complications and comorbidities, or those without. The only subset for which this finding did not hold was cases without detoxification, in which case abuse without detoxification (that is, abuse with other symptomatic treatment) is slightly less expensive and has a shorter length of stay, on average, than dependence without detoxification. The current distinction between abuse and dependence diagnoses contributes virtually nothing to homogeneity with respect to mean charges or length of stay. As this finding was consistent with the conclusions from the ADAMHA reabstraction study, we decided to collapse the two DRGs (434 and 435) into a single group and to examine other variables to explain differences in resource use.

We determined that the use of complications and comorbidities, excluding diagnoses in MDC 20 from the list of complications and comorbidities, to split these cases into two groups explains significant differences in resource use and improves overall homogeneity more than classifying cases based on presence or absence of detoxification. Moreover, the differential between cases with complications and comorbidities and those without consistently exceeds 40 percent across the ADAMHA reabstract study cases and both the FY 1985 and FY 1986 bill files. Therefore, we are proposing to restructure DRGs 434 and 435 by combining alcohol/drug abuse and dependence cases with detoxification or other symptomatic treatment and then to partition them based on presence or absence of non-MDC 20 complications and comorbidities. DRG 434 would become Alcohol/Drug Abuse or Dependence, Detoxification and/or Other Symptomatic Treatment, with C.C., and DRG 435 would become Alcohol/Drug Abuse or Dependence, Detoxification and/or Other Symptomatic Treatment, without C.C.

Based on the ADAMHA findings, we then evaluated the appropriateness of partitioning DRG 437 on the basis of non-MDC 20 complications and comorbidities as well. However, we found that presence or absence of complications or comorbidities contributed little to improving the resource homogeneity of the two resulting DRGs; more significantly, the resulting payment differential between complicated and uncomplicated cases was between eight and ten percent, which we believe is too small a differential to warrant creation of a new DRG. By way of comparison, of over 100 DRG pairs currently split on age or C.C., the charge differential between complicated and uncomplicated cases averages 45 percent and is less than 20 percent for only five pairs. When age is eliminated, the average charge differential for complicated versus uncomplicated cases rises to almost 60 percent and is less than 20 percent for only two pairs.

The weighting factors and outlier thresholds appearing in Table 5 for the alcohol/drug DRGs reflect the effects of our proposed restructuring of these DRGs and are based on billing data for Medicare discharges in FY 1986 from short-stay hospitals, alcohol hospitals and alcohol units. We have chosen to use the FY 1986 database because it is the most current and reasonably complete database available at this time. It reflects nearly the entire universe of alcohol/drug cases from the facilities that are or will be subject to the prospective payment system during FY 1988. As noted previously, the distribution of alcohol and drug abuse cases across DRGs in FY 1986 is comparable to the distribution found in the reabstract study. Data from FY 1986 are being used across all DRGs and will obviate the need to make adjustments for volume changes that would result from using a different database to establish the alcohol/drug DRG weights.

Moreover, use of FY 1986 data ensures that the charge data on which the weighting factors for DRGs in MDC 20 are based are consistent with the charge data used to establish the weighting factors for all the other DRGs and with the data used to estimate the average charge for the average case, which represents the denominator used to derive each DRG weight. As we have noted in previous prospective payment system notices, the weights for the alcohol DRGs, as for all other DRGs, reflect resource intensity of the Medicare population in each DRG relative to the average Medicare case. We would expect that the weights and lengths of stay could vary substantially for other patient populations. Because Medicare beneficiaries are either elderly or disabled, the treatment patterns and resource use associated with this population may be very different from those associated with younger or non-disabled patients.

C. Surgical Hierarchies

In the FY 1986 DRG classification changes set forth in the September 3, 1985 final rule, we revised the surgical hierarchies in numerous MDCs to coincide with resource utilization as indicated by the Medicare data used to compute the DRG weighting factors. The exception to this process was MDC 7, in which we found a significant number of cases involving both diagnostic and therapeutic biliary tract procedures. Regardless of whether we ordered diagnostic or therapeutic procedures first in the hierarchy, the extensive occurrence of cases in which both types of procedures were performed resulted in the anomalous situation that the class of procedures ordered first was less resource intensive than the one ordered last

We propose to reorder the surgical hierarchies in each MDC, except MDC 7, consistently with our policy for FY 1986, based on the 1986 PATBILL data that will be used for recalibrating the DRGs for FY 1988. The surgical hierarchy is based upon procedure groups. Consequently, in most cases, hierarchy has an impact on more than one DRG. The methodology for determining the more resource intensive procedure groups, therefore, involves weighting each DRG for frequency to determine the average resources for each procedure group. For example, assume procedure group A includes DRGs 1 and 2 and procedure group B includes DRGs 3, 4, and 5, and that the weighting factor for DRG 1 is higher than DRG 3, but the weights for DRGs 4 and 5 are higher than the weight for DRG 2. To determine the surgical hierarchy, we would weight the weighting factor of each DRG for frequency to determine average resource consumption for the group of procedures and order the procedure groups from that with the highest to that with the lowest average resource utilization, with the exception of "Other O.R. procedures" as discussed below.

This methodology may occasionally result in a case involving multiple procedures being assigned to the lower weighted DRG of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER searches for groups of procedures that sometimes occur in multiple DRGs, this result is unavoidable. However, we anticipate that such occurrences would be minimal.

We should also point out that the "other O.R. procedure" group is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs regardless of the fact that the weighting factor for the DRG(s) in that procedure group may be higher than other procedure groups in the MDC. The "other OR procedures" group is a group of procedures that are least likely to be related to the diagnosis in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

Based on the preliminary recalibration of the DRGs, we are proposing to modify the surgical hierarchy as set forth below. As discussed below in Section II.D., we anticipate that the final recalibrated weights will be somewhat different than those proposed, as they will be based on more complete data. Consequently, further revision of the hierarchy, using the above principles, may be necessary in the final rule.

We are proposing to revise the surgical hierarchy as follows:

1. In MDC 2, order Orbital Procedures before Retinal Procedures.
2. In MDC 3, reorder the procedure groups as follows:
   - Major Head and Neck Procedures
   - Tonsil and Adenoid Procedures Except Tonsillectomy and/or Adenoidectomy Only
   - Cleft Lip and Palate Repair
   - Sialoadenectomy
   - Myringotomy with Tube Insertion
   - Sinus and Mastoid Procedures
   - Salivary Gland Procedures Except Sialoadenectomy
   - Miscellaneous Ear, Nose and Throat Procedures
   - Rhinoplasty
   - Tonsillectomy and/or Adenoidectomy Only
   - Other, Ear, Nose and Throat O.R. Procedures
3. In MDC 5, reorder the procedure groups as follows:
   - Heart Transplant
   - Cardiac Valve Procedure with Pump
   - Coronary Bypass
   - Other Cardiothoracic Procedures
   - Major Reconstructive Vascular Procedures
   - Permanent Cardiac Pacemaker Implantation
   - Amputation Except Upper Limb and Toe
   - Vascular Procedures Except Major Reconstructive Procedures

Amputation Upper Limb and Toe
Cardiac Pacemaker Replacement and/or Revision
Vein Ligation and Stripping
Other Circulatory System O.R. Procedures

4. In MDC 6, reorder the procedure groups as follows:
Stomach, Esophageal and Duodenal Procedures
Rectal Resection
Major Small and Large Bowel Procedures
Peritoneal Adhesiolysis
Appendectomy
Minor Small and Large Bowel Procedures
Mouth Procedures
Anal and Stomal Procedures
Hernia Procedures
Other Digestive System O.R. Procedures

5. In MDC 8, reorder the procedure groups as follows:
Bilateral or Multiple Major Joint Procedures of the Lower Extremity
Wound Debridement and Skin Graft Except Hand
Major Joint and Limb Reattachment Procedures
Hip and Femur Procedures Except Major Joint
Amputations
Back and Neck Procedures
Biopsies
Lower Extremity and Humerus Procedures Except Hip, Foot, Femur
Major Shoulder/Elbow Procedures or Other Upper Extremity Procedures with C.C.
Knee Procedures
Soft Tissue Procedures
Arthroscopy
Local Excision and Removal of Internal Fixation Devices Except Hip and Femur
Major Thumb or Joint Procedures or Other Hand or Wrist Procedures with C.C.
Foot Procedures
Shoulder, Elbow or Forearm Procedures Except Major Joint Procedures without C.C.
Hand or Wrist Procedures Except Major Joint Procedures without C.C.
Other Musculoskeletal System and Connective Tissue O.R. Procedures

6. In MDC 11, order Minor Bladder Procedures above Prostatectomy.

D. Recalibration of DRG Weights

One of the basic issues in recalibration is the choice of a data base that allows us to construct relative DRG weights that most accurately reflect current relative resource use. As mentioned above, the recalibration of DRG weights for discharges occurring in FY 1986 used hospital charge information from the FY 1984 PATBILL data set. For a discussion of the options we considered and the reasons why we chose to use charge data for the FY 1986 recalibration, we refer the reader to the June 10, 1985 proposed rule (50 FR 24372) and the September 3, 1985 final rule (50 FR 35652).

We are proposing to use the same methodology for the FY 1988 recalibration as we did for FY 1986. That is, we would recalibrate the weights based on charge data for Medicare discharges occurring in FY 1986. However, we would use the FY 1986 Medicare provider analysis and review (MEDPAR) file rather than the PATBILL data used in the DRG recalibration that was effective for discharges beginning in FY 1986. The MEDPAR file contains the same data as the PATBILL file but is in a simplified, reformatted record layout. In addition, MEDPAR is now based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills rather than for a 20-percent sample of beneficiaries.

In addition, because the DRG weights are to be used to calculate prospective payments to hospitals in Puerto Rico beginning with discharges on or after October 1, 1987 and to alcohol/drug hospitals and units effective with cost reporting periods beginning on or after October 1, 1987, bills from these hospitals would be included in the data set used to recalibrate the weights.

The proposed recalibrated DRG relative weights are constructed from FY 1986 MEDPAR data received by HCFA through February 1987, which contain almost 90 percent of all Medicare discharges occurring in FY 1986 from those hospitals that will be subject to the prospective payment system in FY 1988. The MEDPAR file data includes approximately 9.5 million Medicare discharges.

The methodology used to calculate the proposed DRG weights from the MEDPAR file is as follows:

- All the claims were regrouped using the proposed revised DRG classifications proposed in a notice published in the Federal Register on May 19, 1987 (52 FR 18877) and including the proposed revisions of the alcohol and drug abuse DRGs and of the surgical hierarchy, as described above.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education payments, disproportionate share payments and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers using the same criterion as was used in computing the current weights. That is, all cases outside of 3.0 standard deviations from the mean of the log distribution of charges per case for each DRG were eliminated.
- The average charge for each DRG was then recomputed excluding the statistical outliers and divided by the national average standardized charge per case to determine the weighting factor.
- In establishing the weighting factor for heart transplants (DRG 103), we used data for the 46 heart transplant cases (from 20 hospitals) in the FY 1986 MEDPAR file consistently with the methodology for all other DRGs. After removing statistical outliers, there were 45 cases on which the weight was based. Because heart transplants were not a Medicare covered service in FY 1986, we verified that the 20 hospitals whose cases were used to establish the weight were in fact hospitals that perform heart transplants.
- No adjustments were made to the charges to remove capital-related and direct medical education costs, as hospitals do not make discrete charges for these components of inpatient hospital services. Accordingly, we do not have the ability to remove capital or direct medical education costs from charge information. Charge data are based on hospital billings for services. These bills represent hospital prices that we assume are intended to cover all fixed and variable costs, whether for capital, medical education or operating. Further, weighting factors based on total charges have been found to have a high degree of correlation with weighting factors based on operating costs only. In the 1981 database used to compare relative weights base on costs and those based on charges, the Spearman correlation coefficient, which measures the correspondence of the rank ordering of pairs of observations, and the Pearson product moment correlation coefficient, which measures the correspondence of actual values between two sets of observations, are both greater than .99. These results reflect a very high degree of correspondence between cost-based and charge-based weights, thereby eliminating the need for making any further adjustment to remove capital or direct medical education costs.
- Kidney acquisition costs continue to be paid on a reasonable cost basis but, unlike other excluded costs, kidney acquisition costs are concentrated in a

single DRG (DRG 302, Kidney Transplantation). For this reason, it was necessary to make an adjustment to prevent the relative weight for DRG 302 from including the effect of kidney acquisition costs, since these costs are paid separately from the prospective payment rate. Kidney acquisition charges were subtracted from the total charges for each case in DRG 302 prior to computing the average charge for the DRG and prior to eliminating statistical outliers.

The weights developed according to the methodology described above, using the revised GROUPER program, result in an average case weight that is slightly different from the average case weight before recalibration. Therefore, the new weights were normalized by an adjustment factor so that the average case weight after recalibration is equal to the average case weight prior to recalibration. This adjustment is intended to ensure that recalibration by itself nether increases nor decreases total payments under the prospective payment system.

When we recalibrated the DRG weights for FY 1986, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. At that time, there were 30 DRGs that contained no cases or fewer than 10 cases. We propose to use that same case threshold in recalibrating the DRG weights for FY 1988. In addition, in the FY 1986 recalibration, we computed the weight for the 30 low-volume DRGs by adjusting the original weights of these DRGs by the percent change in the weight of the average case in the remaining DRGs. We proposed to use this same methodology for the FY 1988 recalibration.

Using the FY 1986 MEDPAR data set, there are 32 DRGs that contain fewer than 10 cases. Since we have no new data upon which to base the weights for these DRGs, we held their current weight constant. This preserves the relationship between the weighting factor for each low-volume DRG and the average case weight for all Medicare cases.

III. Proposed Changes to the Hospital Wage Index Methodology

Section 1886(d)(2)(C)(ii) of the Act required, as a part of the process of developing separate urban and rural standardized amounts for FY 1984, that we standardize the average cost per case of each hospital for differences in area wage levels. Section 1886(d)(2)(H) of the Act requires that the standardized urban and rural amounts be adjusted for area variations in hospital wage levels as part of the methodology for determining prospective payments to hospitals. To fulfill both requirements, we constructed an index that reflects average hospital wages in each urban or rural area relative to a national average hospital wage.

For purposes of determining the prospective payments to hospitals in FY 1984 and FY 1985, we constructed the wage index using calendar year 1981 hospital wage and employment data obtained from the Bureau of Labor Statistics' ES 202 Employment, Wages and Contributions file for hospital workers. However, the September 3, 1985 final rule set forth a revised hospital wage index that was based on an HCFA survey of 1982 hospital wage and salary data as well as data on paid hours in hospitals. That wage index was developed in an attempt to overcome the limitation of the BLS data with regard to full-time and part-time employment. As a result of the provisions of section 9103(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272), application of the revised wage index was postponed from discharges occurring on or after October 1, 1985 to discharges occurring on or after May 1, 1986. The method used to compute the current HCFA wage index was set forth in detail in the September 3, 1985 final rule (50 FR 35661). In the September 3, 1986 final rule, we stated that we were collecting data as part of the audit of cost reports for the first year of the prospective payment system (FY 1984) in order to update the HCFA wage index (51 FR 31499).

Section 9103(a) of Pub. L. 99-272 states that for discharges occurring on or after September 30, 1986, "the Secretary shall provide for such periodic adjustments in the appropriate wage index used under [section 1886(d)(3)(E) of the Act] as may be necessary. . . ." Under the authority of that section, we are proposing to make a change in the methodology for computing the national average hourly wage, which serves as the basis for indexing the area wage levels. We are also proposing to adopt a blended wage index that incorporates the wage index based on 1982 data but computed using the proposed revised methodology discussed below and a new wage index based on 1984 data and also computed using the proposed methodology.

Currently, the wage index value for an area is computed by dividing the area's average hourly wage by the national average hourly wage. The national average hourly wage is computed by summing the average hourly wages for each area and dividing by the number of areas. Thus, the average hourly wage for each area is weighted equally in determining the national average hourly wage regardless of the number of hospitals or the size of the hospital labor force in the area.

Using the current methodology (that is, an area-weighted national average hourly wage) leads to a problem whenever the wage data for hospitals in an area are adjusted or when hospitals are reclassified from one area to another. When either of these situations occurs, the national average hourly wage is affected, and thus the wage index values of all areas change. Since the HCFA wage index was first published in the September 3, 1985 final rule, it has been recomputed three times to reflect adjustments in the wage data for a few areas. Since these changes affected the national average hourly wage, the index values for all areas had to be recomputed.

We are proposing to compute the national average hourly wage by dividing the total wages for all hospitals by the total paid hours. This would result in a wage index that is hour-weighted rather than area-weighted. If the national average hourly wage were hour-weighted, there would be minimal, if any, impact on that national average when the wage data for a particular area are adjusted.

For example, if wage data adjustments are necessary because hospitals are reclassified from one area to another, there would be no need to recompute the national average hourly wage, since total wages and total hours would not have changed due to these reclassifications. Only the wage index values for the affected areas would have to be recomputed. By hour-weighting the national average hourly wage, we can avoid the administrative burden of repeatedly revising all the area wage index values and explaining to hospitals why their wage index values changed even when there has been no change in the data for their areas.

While the change in methodology for computing the national average wage would not affect the relative wage levels among areas, it would result in lower index values for all areas relative to the national average hourly wage, since the national average hourly wage is higher under our revised methodology than it would be if computed on an area-weighted basis. It is important to note that the choice of the base (that is, the national average hourly wage) used to index each area's wage level has no effect on the Federal portion of a hospital's prospective payment, as long as a wage index computed on the same basis is used both to standardize the

Federal payment rates and to derive the payment amount applicable to each area. (For a demonstration of this point, see the September 3, 1985 final rule (50 FR 35664).) In section II.A.1.a. of the addendum to this proposed rule, we discuss restandardization of the Federal payment amounts to reflect this proposed new method of computing the national average hourly wage.

In addition to proposing use of a revised methodology for computing the national average hourly wage, we are proposing, under the exceptions and adjustments authority in section 1886(d)(5)(C)(iii) of the Act, to adopt a blended wage index that incorporates both 1982 and 1984 wage data from prospective payment hospitals. The index would be based on area wage index values computed from 1982 data on an hour-weighted basis and area wage index values computed from 1984 data on an hour-weighted basis, equally weighted to produce average area wage index values.

We believe that a blended wage index is the best way to update the wage index, and at the same time, mitigate any adverse effects that might result from abrupt changes in individual wage index values. Specifically, adoption of a wage index based solely on 1984 data would, for some areas, result in abrupt, large changes in wage index values because of economic changes in certain areas that have occurred between 1982 and 1984. We believe that it is in the best interest of hospitals, as well as the Medicare program, that these changes be reflected gradually in the wage index values.

The method used to compute the proposed wage index is as follows:

Procedure I: Recomputation of the 1982 Wage Index on an Hour-Weighted Basis.

Step 1—Each of the non-Federal acute care hospitals subject to the prospective payment system for which 1982 data were received was classified into its appropriate urban or rural area based on the current definitions of urban and rural areas used in the prospective payment system.

Step 2—For each hospital, the total gross hospital salaries were inflated from the end of the hospital's cost reporting year through the end of calendar year 1982, using the 1982 annual rate of increase in the wages and salaries portion of the hospital market basket. This was done to eliminate any distortion caused by differing hospital cost reporting years.

Step 3—For each hospital, the inflated gross hospital salaries computed in step 2 were divided by the reported number of total paid hours to yield an average hourly wage. Hospitals with an aberrant hourly wage, which was defined as an hourly wage either less than $3.35 (the minimum wage in 1982) or greater than $19.58 (2.5 times the 1982 national average hourly hospital wage as reported in BLS *Employment and Earnings Bulletin* as of February 1984), were excluded.

Step 4—Within each urban or rural area, the total gross hospital salaries as computed in step 2 were summed for all hospitals not excluded in step 3 to yield the total gross hospital salaries in each area.

Step 5—The total gross hospital salary result computed in step 4 was divided by the corresponding total number of paid hours in the area to yield an average hourly wage for each urban and rural area.

Step 6—The total inflated gross hospital salaries computed in step 2 for all wages not eliminated due to aberrant wage data were divided by the reported number of total paid hours in these hospitals to obtain the national average hourly hospital wage based on gross salaries. This national average is $8.52.

Step 7—For each urban or rural area, the hospital wage index value was calculated by dividing the average hourly wage computed in step 5 by the national average hourly wage.

Procedure II: Computation of the 1984 Wage Index

Step 1—Each of the non-Federal acute care hospitals subject to the prospective payment system for which 1984 data have been received (including hospitals in Puerto Rico) was classified into its appropriate urban or rural area based on the current urban area definitions used in the prospective payment system.

Step 2—For each hospital, the total gross hospital salaries as reported for hospital fiscal years that began in FY 1984 were inflated from the end of the hospital's cost reporting year through August 31, 1985 using the percentage change in average hourly earnings of hospital industry workers (S.I.C. 806) in BLS *Employment and Earnings Bulletin*. This was done to eliminate any distortion in the data caused by differing hospital cost reporting years. (August 31, 1985 was the latest end date for hospital cost reporting years in the data collection.)

Step 3—For each hospital, the inflated gross hospital salaries computed in step 2 were divided by the reported number of total paid hours to yield an average hourly wage. Hospitals with an aberrant average hourly wage, which was defined as an average hourly wage either less than $3.35 (the minimum wage in 1984) or greater than $23.61 (2½ times the national average hourly wage as computed from the data collected), were excluded.

Step 4—Within each urban or rural area, the result computed in step 2 was summed for all remaining hospitals to yield the total gross hospital salaries in each area.

Step 5—The total gross hospital salary result computed in step 4 was divided by the corresponding total number of paid hours in the area to yield an average hourly wage for each urban or rural area.

Step 6—The inflated gross hospital salaries computed in Step 2 for all hospitals not eliminated due to aberrant wage data were divided by the reported number of total paid hours in these hospitals to obtain the national average hourly hospital wage based on gross salaries. This national average is $9.76.

Step 7—For each urban or rural area, the hospital wage index value was calculated by dividing the average hourly wage computed in step 5 by the national average hourly wage

Procedure III: Computation of a Wage Index for all Hospitals Except Those Located in Puerto Rico, Based on a Blend of the 1982 Wage Index (Computed Under Procedure I) and the 1984 Wage Index (Computed Under Procedure II)

Step 1—Wage index values for each urban and rural area computed using 1984 data (Procedure II, step 7) were matched to the corresponding urban and rural wage index values computed using 1982 data (Procedure I, step 7). For both indexes, areas were classified as urban or rural using the current definitions.

Step 2—A blended wage index value for each urban and rural area was computed by adding the 1982 and 1984 wage index values and dividing the result by 2.

Example

If an area's 1982 wage index value is 0.8888 and its 1984 wage index value is 0.9000. The blended wage index value is obtained as follows:

$$\frac{(0.8888+0.9000)}{2} = \frac{1.7888}{2} = 0.8944$$

The results obtained in step 2 constitute the wage index values for each urban and rural area.

For hospitals located in Puerto Rico, the wage index values would not be the result of a blend, but would instead be based solely on 1984 data. We do not have usable 1982 wage data for Puerto

Rico hospitals since these hospitals were not subject to the prospective payment system in 1984 and 1985 when we collected the 1982 wage data from prospective payment hospitals.

To avoid unnecessary confusion, we are publishing only the blended wage index that we are proposing to use for payment purposes. However, as with other data we use to set the prospective payment rates, both the 1982 and the 1984 hour-weighted wage indexes, as well as the wage data used to derive them, will be made available to any interested parties upon request.

IV. Inclusion of Puerto Rican Hospitals in the Prospective Payment System

When section 1886(d) was added to the Act by Pub. L. 98-21, all hospitals located outside the 50 States and the District of Columbia were excluded from the prospective payment system and thus have continued to be paid on the basis of reasonable costs subject to the rate-of-increase limits established by section 1886(b) of the Act. However, section 9304(a) of Pub. L. 99-509 added a new section 1886(d)(9) to the Act to include eligible Puerto Rico hospitals in the prospective payment system effective with discharges occurring on or after October 1, 1987.

Section 1886(d)(9)(A) following (ii) of the Act specifies that a hospital is subject to the prospective payment system if it is located in Puerto Rico and otherwise would be subject to that system if it were located in one of the 50 States. Although eligible Puerto Rico hospitals are to be included in the prospective payment system, there are some special rules that apply to those hospitals.

Section 1886(d)(9)(A) of the Act specifies that the payment per discharge under the prospective payment system for hospitals in Puerto Rico is to be the sum of—

- 75 percent of the Puerto Rico discharge-weighted urban or rural standardized rate.
- 25 percent of a national discharge-weighted standardized rate.

Separate urban and rural standardized payment rates would be computed for Puerto Rico. For FY 1988, section 1886(d)(9)(B)(i) of the Act specifies that this be done in the same manner we used to compute the regional standardized rates under section 1886(d)(2) of the Act except that the rate would be based on the Puerto Rico hospitals' target amounts, as defined in section 1886(b)(3)(A) of the Act, that are applicable for cost reporting periods beginning on or after October 1, 1986, updated to the midpoint of FY 1988 by prorating the applicable percentage increase (that is, the percentage increase in the market basket index minus 2.0 percentage points). We note that the Puerto Rico standardized amounts, which are based on the Puerto Rico hospitals' target rates, are not subject to revision once those amounts are calculated. While target rates for particular years may be revised under existing regulations for purposes of determining the amounts of payment for those years under the reasonable cost reimbursement principles, to permit their revision to affect the Puerto Rico standardized amounts would, in effect, defeat Congress' intention that the standardized amounts be prospectively determined based on the best data available.

If we were to allow constant revision of the Puerto Rico standardized amounts based on changes to the hospitals' target rates, we would create continuing uncertainty as to what the prospective prices are. Also, for years after FY 1988, section 1886 (d)(9)(C)(i) of the Act requires that the previous year's Puerto Rico standardized amounts be updated by the applicable percentage increase determined for the prospective payment system. We do not believe that Congress contemplated changes in those amounts because of revisions in the data base.

Revising the Puerto Rico standardized amounts to take into account revisions in target rates would be contrary to our policy that we not make changes to the standardized amounts because of changes to the data base used to calculate the standardized amounts. We believe our policy is in accordance with Congressional intent to use the best data available. We note that we did not revise the original prospective payment standardized amounts that were effective October 1, 1983 to take into account revisions in the data that were used to calculate those amounts (that is, cost reports for reporting periods ending in calendar year 1981). Therefore, we would allow revisions in the target rates for individual cost reporting periods subject to the rate-of-increase limits under the current regulations for purposes of determining payment for those periods. However, these revisions would have no impact on the data used for the computation of the Puerto Rico standardized amounts. Under section 1886(d)(9)(A)(ii) of the Act, the national standardized rate that makes up 25 percent of the payment rate for Puerto Rico hospitals consists of the discharge-weighted average of the national rural standardized amounts and the national urban standardized amounts that are used for paying all prospective payment hospitals outside of Puerto Rico.

As required by section 1886(d)(9)(B)(vi) of the Act, the labor-related portion of the Puerto Rico standardized amount is adjusted by the appropriate wage index value for the area in which a Puerto Rico hospital is located. We are proposing to include Puerto Rico in the HCFA wage index that is used for all prospective payment hospitals and to adjust the Puerto Rico standardized amount for each area to reflect the average wage level relative to the national average wage. The inclusion of Puerto Rico in the national wage index accomplishes the result required by the law (that is, the Puerto Rico index reflect each area's wage level relative to the Puerto Rico average) since the relative differences among the Puerto Rico areas remains the same regardless of the average wage level used as the denominator of the index. As discussed above in section III, the choice of the denominator used to index each area's wage level has no effect on the hospital's prospective payment as long as the same wage index is used both to standardize the payment rates and to derive the payment amount applicable to each area. Therefore, for administrative ease and convenience, we would include Puerto Rico in the wage index used for all other hospitals in the system.

For FY 1989 and subsequent fiscal years, section 1886(d)(9)(C)(i) of the Act specifies that the Puerto Rico standardized amount is to be updated by the applicable percentage increase determined by the Secretary under section 1886(e)(4) of the Act. Section 1886(e)(4) of the Act further specifies that the update factor applied to Puerto Rico hospitals must be the same as the update factor applied to prospective payment hospitals located in the 50 States and the District of Columbia.

Section 1886(d)(9)(D) of the Act specifies that the following provisions of section 1886(d)(5) of the Act concerning additional payments to, or special treatment of, prospective payment hospitals also apply to prospective payment hospitals in Puerto Rico:

- Section 1886(d)(5)(A) of the Act, which requires that additional amounts be paid for outlier cases.
- Section 1886(d)(5)(B) of the Act, which requires that additional amounts be paid for indirect medical education costs.
- Section 1886(d)(5)(C)(iii) of the Act, which authorizes the Secretary to make other exceptions and adjustments as the Secretary deems appropriate.
- Section 1886(d)(5)(E) of the Act, which permits payment on a reasonable cost basis for anesthesia services

furnished in a hospital by a certified registered nurse anesthetist (CRNA).

• Section 1886(d)(5)(F) of the Act, which authorizes additional payment for hospitals that serve a disproportionate share of low-income patients.

The following provisions of section 1886(d)(5) of the Act do not apply to prospective payment hospitals in Puerto Rico:

• Special treatment of referral centers (section 1886(d)(5)(C)(i) of the Act).

• Special treatment of sole community hospitals (section 1886(d)(5)(C)(ii) of the Act).

The following types of hospitals and hospital costs that receive special treatment in the prospective payment system under section 1886(d)(5)(C)(iii) of the Act would also receive special treatment for hospitals located in Puerto Rico:

• Hospitals involved extensively in treatment for and research on cancer that meet the requirements of § 412.94.

• Christian Science Sanatoria.

• Hospitals that are located in urban areas and that are reclassified as rural, as described in § 412.102.

• Hospitals with a high percentage of discharges for end-stage renal disease patients, as described in § 412.104.

• Hospitals approved as renal transplantation centers.

• Hospitals in redesignated rural counties that are surrounded on 95 percent of their perimeters by urban counties, as described in § 412.63(b)(3).

We are proposing to add a new Subpart K to Part 412 to implement the special rules that would apply to prospective payment hospitals located in Puerto Rico. Conforming changes would also be made in §§ 412.23(f).

Section 1886(e)(1)(C) of the Act, as added by section 9304(c) of Pub. L. 99-509, requires that for discharges occurring in FY 1988, the aggregate payment to prospective payment hospitals including those hospitals located in Puerto Rico be equal to the aggregate payment that would have been made to those hospitals under prior law; that is, the addition of hospitals in Puerto Rico to the prospective payment system must be "budget neutral".

A detailed explanation of the methodology we propose to use to calculate the payment rates for hospitals in Puerto Rico, as well as the budget neutrality issue, is set forth in sections III and IV of the addendum to this proposed rule.

V. Other Decisions and Proposed Changes to the Regulations

A. Review of DRG Assignments (§§ 412.60 and 466.70)

We have encountered situations in which a hospital that submits a claim to Medicare for payment later attempts to resubmit the claim based on additional information that would place the case in a higher-weighted DRG. Some corrections of billing information are warranted if, for example, the hospital omitted critical documentation or misread the medical record. We believe that it is appropriate to allow a hospital a reasonable period of time in which to correct its own error by submitting additional or corrected information on an adjustment bill. Nevertheless, as in the case of any business transaction, we do not believe it is appropriate for the billing party to revise a claim long after the original claim is submitted and paid.

The September 1, 1983 interim final rule included a discussion of the review of DRG coding errors as follows:

> Intermediaries will assign discharges to DRG's initially. Where errors in coding occur, the hospital may resubmit the billing data with the revised coding for the case. Additionally, the hospital may request individual review of claims. The review would be appropriately conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination. However, in general, the DRG classification system may not be appealed. (48 FR 39784–39785.)

Allowing hospitals an extended period of time to discover errors and to resubmit bills is contrary to good business practice. A workable prospective payment system would not exist if the fiscal intermediaries are constantly processing recoded claims based upon the same documentation or if bills lack finality because they are forever subject to revision.

Therefore, effective April 23, 1984, we established an informal review mechanism through adninistrative directive by issuing changes to the following manuals:

• Hospital Manual (HCFA Pub. 10), section 287.5, transmittal number 382.

• Medicare Intermediary Manual (HCFA Pub. 13–3), section 3798, transmittal number 1109.

These issuances specified that a hospital has 60 days after the date of an initial DRG assignment to a claim to request review The hospital may submit additional information as a part of its request The fiscal intermediary reviews the data and adjusts the DRG if appropriate.

As part of the PRO's review responsibility, the initial PRO contract cycle provided for review of hospital requests for DRG claims adjustments submitted after the initial claim had been filed. This review applied only if the intermediary's review resulted in the assignment of a higher-weighted DRG and the PRO had not previously reviewed the case in question. Because these claims adjustments were considered to represent a high risk of DRG manipulation, 100 percent of these cases were reviewed postpayment. The PRO not only determines if the request for coding changes is appropriate, but also conducts full PRO review of the case if this review was not performed previously. The PRO's collected data on the frequency with which hospitals submitted erroneous requests for DRG claim adjustments. Identification by the PRO of a pattern of inappropriate coding adjustments required corrective actions. The second PRO ccntract cycle effective July 1, 1986 requires that this review be conducted on a prepayment basis.

We are proposing to include the provisions of the manual instructions concerning hospitals requests for review of DRG assignments in the regulations Thus, we are merely clarifying in regulations what is already our current operating policy. We would revise § 412.60 to specify that a hospital has 60 days to request a review by the intermediary of a DRG assignment and to describe how that review is conducted. In addition, we would revise § 466.70 to provide that a PRO must review every case in which a higher-weighted DRG is assigned to a discharge as a result of the intermediary's review.

B. Increase in the Prospective Payment Rates and Rate-of-Increase Limits (§§ 412.63, 412.73, and 413.40)

Section 9302(a)(1) of Pub L. 99–509 amended section 1886(b)(3)(B)(i)(II) of the Act to provide that the applicable percentage increase for FY 1987 is 1.15 percent and for FY 1988 is the market basket percentage increase minus 2.0 percentage points. The November 24, 1986 final rule amended §§ 412.63, 412.73, and 413.40 to implement the changes applicable to FY 1987. As a part of this proposed rule, we would amend those same sections to implement the provisions of section 1886(b)(3)(B)(i)(II) of the Act applicable to FY 1988.

C. Payment for Outlier Cases (§§ 412.82 and 412.84)

Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made to hospital for atypical cases known as "outliers". These are cases that have either an extremely long

length of stay or extraordinarily high costs when compared to the other discharges classified in the same DRG.

Section 1886(d)(5)(A)(iii) of the Act specifies that the outlier payments should approximate the marginal cost of care beyond the outlier threshold. In the September 1, 1983 interim final rule, we established the ratio of marginal cost to average cost at 60 percent (48 FR 39776). Therefore, the regulations (§§ 412.82 and 412.84) currently provide that the marginal cost of outlier cases is based on a 60 percent factor.

For day outliers, an additional per diem payment is made for each covered day of care beyond the threshold. The per diem payment is based on 60 percent of the average per diem Federal rate for the DRG, which is calculated by dividing the wage-adjusted Federal rate for the DRG by the geometric mean length of stay for that DRG. During the transition period (cost reporting periods beginning on or after October 1, 1983 and before October 1, 1987), this amount is multiplied by the applicable Federal blend percentage. Starting with cost reporting periods beginning on or after October 1, 1987, the Federal portion is 100 percent of the payment rate.

For cost outliers, the additional payment is based on 60 percent of the difference between the hospital's adjusted charges for the discharge and the outlier threshold. The cost of the discharge is based on 66 percent of the billed charges for covered services. The cost is further adjusted to exclude an estimate of indirect medical education costs and payments for hospitals that serve a disproportionate share of low-income patients. As with day outliers, the resulting amount is then multiplied by the applicable Federal portion of the blend.

Our analysis indicates that while our payment policy for outliers effectively reduces the risk faced by hospitals in treating cases that are outside the normal range of cases in terms of days of care or costliness, additional compensation would be justified for the most expensive cases, particularly those long-stay cases with extremely high costs. On the other hand, some cases that qualify for additional payment as day outliers are not extraordinarily costly.

We are proposing to make two changes to the outlier regulations. First, we would revise our payment policy on day outliers. We currently pay even the most expensive day outliers at a per diem amount that is based on the average payment for all discharges assigned to that DRG. For some of the cases that currently qualify as day outliers (and therefore cannot be cost outliers), the per diem rate paid to those cases does not adequately compensate the hospital for its costs. This is especially true in day outlier cases with extremely high costs (for example, severe burn cases), for which the daily costs vastly exceed the day outlier per diem and for which that daily difference is multiplied by a long length of stay.

We are proposing that if a day outlier case also meets the cost outlier criteria, we would pay the case using the cost outlier methodology. We believe that this change in policy would improve outlier payment equity by basing the payment for high cost day outliers on estimates of actual hospital cost rather than on an average per diem rate. Day outliers that do not meet the cost outlier criteria would continue to be paid on the basis of a per diem rate.

We have also reexamined the 60 percent marginal cost factor used in calculating the payment for outlier cases. Evidence from recent research indicates that a higher marginal cost factor would result in more appropriate payments for the most expensive cases by more effectively reducing the financial risk to hospitals that is associated with these cases. In particular, we note that the estimated loss per case is higher for cost outliers than for day outliers. When day outliers are separated into two categories—those exceeding the day outlier threshold but not the cost outlier, and those exceeding both the day and the cost outlier thresholds—the estimated loss per case for the more expensive day outliers (those also exceeding the cost threshold) substantially exceeds that for the less expensive day outliers (those that do not exceed the cost threshold). (The prospective payment system is not intended to pay for the full costs of every case in every hospital but rather the average costs of the average case. Because outlier cases are, by definition, far different from the average case in each DRG and because the additional payments for outlier cases are based on an estimate of the marginal cost beyond the threshold rather than the full cost associated with each outlier case, we would expect to find that payments for outlier cases are, on average, less than estimated costs for these cases.)

The finding that the financial risk associated with outlier cases varies substantially with whether the case is long stay only or exceeds the cost threshold suggests that the marginal cost factor we are using for the most expensive outliers (those that exceed the cost outlier threshold) is too low. Accordingly, for discharges occurring on or after October 1, 1987, we are proposing to set payment for the most expensive outlier cases (that is, all outlier cases exceeding the cost outlier threshold) at 80 percent of adjusted charges beyond the cost outlier threshold. Based on our research to date, we believe that this revised marginal factor would result in more adequate compensation to hospitals treating the most costly outlier cases. Because this revised marginal cost factor would bring into better balance the risk associated with the most expensive outliers and that associated with long-stay only outliers, we believe it is a closer approximation of the marginal cost of care for the most expensive outliers.

It is important to note that we are continuing our research on the marginal cost of outlier cases. A different marginal cost factor for day outliers may be appropriate once we begin paying the more expensive day outlier cases using the cost outlier methodology, as we are proposing to do. However, until we complete our research, we will continue to pay day outliers that do not also exceed the cost outlier threshold using the current .60 marginal cost factor.

ProPAC agrees with us that the outlier payment policy should be refined to reflect more accurately the resources hospitals use to meet outlier cases (Recommendation No. 17). ProPAC's main concern is that current outlier payments may not adequately protect hospitals from the risk of extremely costly cases. We believe that the changes we have proposed should help remedy this situation.

D. Payments to Sole Community Hospitals (§ 412.92)

Section 1886(d)(5)(C)(ii) of the Act requires that the special needs of sole community hospitals (SCHs) be taken into account under the prospective payment system. The statute specifies a special payment formula for hospitals so classified and further provides for additional payment to SCHs experiencing a significant volume decrease (that is, more than a five percent decrease in total discharges of inpatients) because of circumstances beyond their control. The statute defines SCHs as those hospitals that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), are the sole source of inpatient hospital services reasonably available to Medicare beneficiaries in a geographic area. Regulations governing the special treatment of SCHs under the prospective payment system are set forth in § 412.92.

Currently, § 412.92(e) provides that an SCH is eligible for a payment adjustment in any cost reporting period if it experiences more than a five percent decrease in its total discharges for inpatients as compared to its immediately preceding cost reporting period. To qualify for a payment adjustment, an SCH must submit documentation demonstrating the size of the decrease and the resulting effect on per discharge costs, and show that the decrease is due to extraordinary circumstances beyond the hospital's control, including (but not limited to) strikes, fires, floods, earthquakes, inability to recruit essential physician staff, or unusually prolonged severe weather conditions.

We determine on a case by-case basis whether an adjustment will be granted and the amount of that adjustment. As specified in § 412.92(e)(3), a per discharge payment adjustment, including at least an amount reflecting the reasonable cost of maintaining the hospital's necessary core staff and services, is determined based on the individual hospital's needs and circumstances, the hospital's fixed and semi-fixed costs not paid on a reasonable cost basis, and the length of time the hospital has experienced a decrease in utilization.

Based on our experience with this provision and the applications we have received from SCHs for a volume adjustment, we believe that it is appropriate at this time to clarify the regulations at § 412.92(e). Section 1886(d)(5)(C)(ii) of the Act provides that if an SCH experiences a decrease of more than five percent in its total number of inpatient cases due to circumstances beyond its control, "... the Secretary shall provide for such adjustment to the payment amounts under this subsection ... as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services." We believe that this language makes it clear that a hospital that has continued to make a profit under the prospective payment system even though there has been a decline in occupancy is not entitled to receive a payment adjustment. Hospitals that receive payments that are greater than the hospitals' Medicare inpatient operating costs have been "fully compensated" for those costs by the prospective payment system. Consequently, we believe that no further adjustment should be granted to these hospitals.

We recognize that some SCHs experiencing a volume decline may be having financial difficulties despite the fact that they have recovered their full Medicare inpatient operating costs under the prospective payment system. While it may be true that some SCHs are suffering financial hardship for any number of reasons, it is clearly inappropriate for Medicare to share in the costs attributable to non-Medicare beneficiaries. Consequently, we are proposing to revise § 412.92(e)(3) to make it clear that any adjustment amounts granted to SCHs for a volume decrease may not exceed the difference between the hospital's Medicare inpatient operating costs and total payments made under the prospective payment system, including outlier payments and indirect medical education payments.

This proposed modification of the regulations reflects our current operating policy rather than a change in policy. We believe that reflecting this policy in the regulations would help hospitals in making their decisions about whether to apply for a volume adjustment. By making it clear that we do not grant a volume adjustment to any hospital that has already been fully compensated for its costs, we hope to spare those hospitals the administrative burden of preparing a detailed request for an adjustment.

We are also proposing to revise § 412.92(e)(2)(ii), which currently requires that, in order to receive a volume adjustment, the decline in the hospital's total discharges must be due to extraordinary circumstances beyond the hospital's control. Section 1886(d)(5)(C)(ii) of the Act requires only "circumstances" beyond the hospital's control. Therefore, effective with cost reporting periods beginning on or after October 1, 1987, we would delete the word "extraordinary" from the regulations.

During the early years of the prospective payment system, there were significant volume declines for all hospitals. American Hospital Association survey data indicate that average volume decline for small rural hospitals between 1984 and 1985 was 7.6 percent. During this period, we believe that the reguirement that volume declines be related to extraordinary circumstances was necessary to avoid creating a mechanism that would have completely sheltered SCHs from the incentives intended to apply under the prospective payment system and, thus, would have resulted in inequitable treatment of hospitals. In general, the volume of inpatient hospital admissions has now stabilized. Consequently, we believe it is appropriate to relax the criteria for granting volume declines.

E. Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, in the August 31, 1984 final rule, we added an alternative set of criteria to § 412.96 (then § 405.476(g)) that expanded the definition of a referral center to encompass more rural hospitals. We also added a new paragraph to that section that provides for a triennial review of referral centers to determine if they continue to meet the criteria for a referral center (See 49 FR 34740 for a detailed discussion of those revisions.) Under the alternative criteria, in order to qualify as a referral center, a hospital must meet two mandatory criteria (number of discharges and case-mix index) and at least one of three optional criteria (medical staff, source of inpatients, or volume of referrals), in addition to being located in a rural area.

Section 9302(d)(1) of Pub. L. 99–509 amended section 1886(d)(5)(C)(i) of the Act to provide, with respect to the two mandatory criteria, that a hospital will be classified as a rural referral center if its—

- Case mix index is equal to the median case mix index for urban hospitals in each region, excluding hospitals with approved teaching programs; and
- Number of discharges criteria is at least 5,000 discharges per year or, if less, the median number of discharges for urban hospitals in the region in which the hospital is located.

In the November 24, 1986 final rule, we amended § 412.96(c) to incorporate the changes mandated by section 9302(d)(1) of Pub. L. 99–509, and published the revised case-mix index criteria. As noted in Section I.A. of this preamble, we are in the process of developing a separate **Federal Register** document to revise provisions of the November 24, 1986 final rule concerning referral centers.

1. Case-Mix-Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining referral center status. In determining the proposed national and regional case-mix index values, we would follow the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, the proposed national case-mix index value

is the median case-mix index value of all urban hospitals nationwide and the proposed regional values are the median values of urban hospitals within each census region excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.118).

These values are based on discharges occurring during FY 1986 (October 1, 1985 through September 30, 1986) and include bills posted to HCFA's records through February 1987. Therefore, in addition to meeting other criteria, we are proposing that to qualify for or to retain rural referral center status for cost reporting periods beginning on or after October 1, 1987, a hospital's case-mix index value for FY 1986 would have to be at least—

- 1.1594; or
- Equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.118) calculated by HCFA for the census region in which the hospital is located as indicated in the table below.

Region	Case-mix index value
1	1.1263
2	1.1136
3	1.1354
4	1.1195
5	1.0978
6	1.1492
7	1.1480
8	1.1900
9	1.1755

The above numbers will be revised in the final rule to the extent that additional bills are received for discharges through September 30, 1986.

We are proposing to amend § 412.96(c)(1) to state current policy that the case-mix index used to determine whether a hospital qualifies as a rural referral center is the case-mix index as calculated by HCFA from hospital billing records for Medicare discharges processed by the fiscal intermediary and submitted to HCFA's central office. This policy ensures consistency between the national and regional case mix index standards and the case-mix index values used to determine qualification of a hospital as a rural referral center in that all case-mix index values are derived from hospitals' Medicare prospective payment bills.

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing the FY 1986 case-mix index values in Table 3c of section VI of the addendum to this proposed rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment. The resulting case-mix index values are based on bills received in HCFA through February 1987. These values will be revised in the final rule to the extent that additional bills are received.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(i)(II) of the Act, the national standard is set at 5,000 discharges. However, we are proposing to update the regional standard, which is based on discharges for urban hospitals during the second year of the prospective payment system (that is, October 1, 1984 through September 30, 1985), which is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we are proposing that to qualify for or to retain rural referral center status for cost reporting periods beginning on or after October 1, 1987, a hospital's number of discharges for its cost reporting period that began during FY 1986 would have to be at least—

- 5,000; or
- Equal to the median number of discharges for urban hospitals in the census region in which the hospital is located as indicated in the table below.

Region	Number of discharges
1	6885
2	7689
3	6478
4	7848
5	6724
6	5838
7	4706
8	7157
9	4666

3. Retention Criteria

We are not proposing to update § 412.96(f) at this time since 9302(d)(2) of Pub. L. 99–509 requires that all currently approved rural referral centers will retain the adjustment at least through their cost reporting period beginning during FY 1989. We are, however, soliciting suggestions on the most equitable way to evaluate existing referral centers since some will have been approved for five years, some for four, and some for three.

4. Change in Rate Paid to Rural Referral Centers

The adjustment allowed for approved rural referral centers is that they are paid based on the urban, rather than rural, prospective payment rate as adjusted by the applicable DRG weighting factor and the rural area wage index.

As noted above, section 1886(d)(5)(C)(i) of the Act provides that hospitals with approved teaching programs are not included in determining the median case mix index of urban hospitals within a census region. We defined "teaching" hospitals as those hospitals receiving indirect medical education payments as provided in § 412.118 and issued revised median case mix indexes for each census region.

We are now proposing that these same hospitals be excluded in determining the urban standardized amount paid to approved rural referral centers. We do not believe it is equitable that hospitals with approved teaching programs be excluded from the median regional case mix index calculations but be included in the calculation of the urban standardized amounts. In addition, our own analyses of Medicare cost reports from FY 1984 indicate that rural referral centers' costs, regardless of the basis upon which they qualify, are less than those of the average urban hospital when case mix, teaching status, and wage differences are taken into account, but greater than those of other rural hospitals.

We have determined that deletion of the costs of urban hospitals with approved teaching programs from the calculation of the urban standardized amount would lower the amount by three percent. Therefore, instead of receiving payment based on 100 percent of the urban standardized amount, approved rural referral centers would receive 97 percent of the urban standardized amount. We are proposing to amend § 412.96 (d) and (e) to make these changes.

F. Payment for Services of Nonphysician Anesthetists (§ 412.113)

Section 2312 of the Deficit Reduction Act of 1984 (Pub. L. 98–369), enacted on July 18, 1984, amended sections 1886(a)(4) and 1886(d)(5) of the Act to require that we pay an additional

amount to hospitals for "reasonable costs incurred" for anesthesia services furnished by certified registered nurse anesthetists (CRNAs). Section 2312(a) of Pub. L. 98–369 added section 1886(d)(5)(E) to the Act to provide for payment to hospitals on a reasonable cost basis for the costs that hospitals incur in connection with the services of CRNAs. It further provides that this is the only payment made to the hospital for these services.

Section 1886(a)(4) of the Act, as amended by section 2312(b) of Pub. L. 98–369, excludes anesthesia services furnished by a CRNA from the definition of the term "operating costs of inpatient hospital services." Section 2312(c) of Pub. L. 98–369 specifies that these amendments are effective for hospital cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987.

In implementing this provision of the law, we did not limit its application only to the services of CRNAs. The regulations at § 412.113(c) also apply the exception to the services of anesthesiology assistants. For a detailed discussion of this provision and our implementation of it, see the August 31, 1984 final rule (49 FR 34748).

Section 9320(a) of Pub. L. 99–509 amended section 2312(c) of Pub. L. 98–369 to extend the effective date of the payment on a reasonable cost basis for the services of CRNAs through cost reporting periods beginning before January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but ends after that date, the payment made under 1886(d)(5)(E) of the Act is proportionately reduced to reflect the portion of the period occurring after January 1, 1989. Section 9320 of Pub. L. 99–509 provides that payment on a reasonable cost basis for the services of CRNAs be excluded for any part of a cost reporting period that falls after December 31, 1988. Section 9320(d) of Pub. L. 99–509 revises section 1832(a)(2)(B) of the Act to authorize direct billing for the services of CRNAs on a reasonable charge basis under Medicare Part B (Supplementary Medical Insurance) effective with services furnished on or after January 1, 1989. We are proposing to revise § 412.113(c) to reflect this extension of the effective date and to make conforming changes in § 412.1(a), 412.2(d)(5), and 412.71(b)(8).

The Conference Committee report that accompanies Pub. L. 99–509 states that it is the intention of the conferees that the exception in § 405.553(b)(4), which permits recognition of arrangements in which physicians bill for the services of their anesthetist employees "incident to" their own services, also be extended through December 31, 1988 (H.R. Rep. 99–1012, 99th Cong., 2d Sess. 323 (1986)). (A detailed discussion of this exception is included in the September 1, 1983 interim final rule (48 FR 39794) and later revisions made to the exception are discussed in the August 31, 1984 final rule (49 FR 34748)). We would, therefore, revise § 405.553(b)(4) to reflect the extension of the exception from the usual Part B reasonable charge rules for these anesthesia services.

VI. Other ProPAC Recommendations

As required by law, we have reviewed the April 1, 1987 report submitted by ProPAC and have given its recommendations careful consideration in conjunction with the formulation of the proposals set forth in this document. Recommendation 17 concerning payment of outliers is discussed in section V.C. of this preamble. Except for recommendations 1 through 5 concerning the update factor, 7 through 11 concerning capital, and recommendations 21, 22, and 24 through 26 concerning the DRG classification system, the remainder of the recommendations are discussed below. The recommendations concerning the update factor will be addressed in a separate notice to be published in the **Federal Register.** The recommendations concerning capital are addressed in a separate proposed rule on that subject published in the **Federal Register** on May 19, 1987 (52 FR 18840). The recommendations concerning the DRG classification system are addressed in a separate notice concerning changes to that system published in the **Federal Register** on May 19, 1987 (52 FR 18877).

A. Update Factor

Timely Availability of Medicare Cost Report Data (Recommendation 6)

Recommendation: Medicare cost report data should be routinely collected from a sample of prospective payment hospitals with accounting years that begin in the first four months of the Federal fiscal year. Data from this "early return" sample would provide more timely estimates of the costs of prospective payment hospitals. ProPAC believes these data are necessary for assessing the relationship between prospective payments and hospital costs and for analyzing the costs of individual DRGs. ProPAC will complete further analyses to determine how an early return sample should be developed for hospitals excluded from the prospective payment system but subject to the rate-of-increase limits.

Response: We agree that Medicare cost report data should be available as soon as possible in order to evaluate the performance of hospitals under the Medicare prospective payment system. We have reviewed a study conducted by the Rand Corporation for ProPAC on the feasibility of using cost reports from prospective payment hospitals with cost reporting periods beginning in the first four months of the Federal fiscal year in order to produce cost estimates for all prospective payment hospitals. We are prepared to work with ProPAC staff to implement a system for extrapolating estimated yearly costs from four months of data.

Normally, the Hospital Cost Report Information System (HCRIS) receives cost reports from the Medicare fiscal intermediaries on a "flow" basis. That is, cost reports for hospitals whose reporting periods end early in the Federal fiscal year are received before those reports for hospitals whose reporting periods end later in that year. However, there are a number of situations beyond our control that may cause late submission of the reports by hospitals (and thus delays in the availability of the data) such as a delay in the issuance of revised Medicare cost reporting forms incorporating changes to the forms that result from new legislative provisions. Nonetheless, we will endeavor to make cost report data available in accordance with ProPAC s recommendation, taking into account those factors and situations that may cause delays in the availability of the data or that may make the data unavailable.

B. Adjustments to the Payment Formula

As in previous reports, ProPAC is concerned with achieving technical improvements in the way prospective payments are calculated. ProPAC believes that these improvements will result in a more equitable distribution of payments among hospitals and a lower risk of access and quality problems for beneficiaries.

1. Improving the Definition of Hospital Labor Market Areas (Recommendation No. 12)

Recommendation: The Secretary should adopt improved definitions of hospital labor market areas. For urban areas, the Secretary should modify the current Metropolitan Statistical Areas (MSAs) to distinguish between central and outlying areas. The central areas should be defined using urbanized areas as designated by the Census Bureau. For rural areas, the Secretary should distinguish between urbanized rural

counties and other rural counties within each State. Urbanized rural counties should be defined as counties with a city or town having a population of 25,000 or greater. The implementation of improved definitions should not result in any change in aggregate hospital payments. Furthermore, these definitions should not affect the assignment of hospitals to urban or rural areas for purposes of determining standardized amounts.

Response: For FY 1988, we do not believe that the wage index should be subdivided beyond the MSA/non-MSA distinction. Because the wage index affects every hospital's payment for every discharge, we believe additional study and analysis are necessary in order to evaluate options and determine their impact. However, as new information is developed, we will consider making improvements in labor market area definitions in future years. Our responses regarding ProPAC's urban and rural area recommendations are as follows:

• Urban Hospitals—While subdividing urban areas into downtown "cores" and suburban "rings" could improve the explanatory power of the wage index, such subdivision would significantly increase the number of areas containing only one or two hospitals. Hospitals in these areas would enjoy a virtual pass-through of labor costs associated with Medicare hospital inpatient operating costs. Further, much of the higher wage level of core city hospitals is addressed by the teaching and disproportionate share adjustments. If we were to adopt a separate index for hospitals in urbanized areas, we would have to reconsider our policies with regard to these two adjustments.

ProPAC has recommended that urban areas be subdivided into core and ring areas on the basis of whether a hospital is located within an urbanized area. The Bureau of the Census defines an urbanized area as an area that consists of a central city or cities that, when combined with surrounding closely settled territory ("urban fringe") having a population density of at least 1,000 persons per square mile, has a population of at least 50,000. Typically, urbanized areas cover the built-up areas at the cores of MSAs.

While we agree that the urbanized area classification may capture wage differentials, the use of urbanized areas as a basis for classifying core and ring areas may not be suitable for use in the prospective payment system. Unlike MSAs, which are county-specific, urbanized areas are defined according to actual population density and are specific to the city-block level. Also, because of the population-density basis for classifying urbanized areas, the boundaries of areas that would meet the 1,000 person per square mile criterion tend not to be stable. However, the Bureau of the Census updates urbanized areas only every 10 years. As a result, many areas that would meet the density criterion may not be classified as being in an urbanized area. Further, because urbanized areas are defined below the census-tract (and also below the MSA) level, it is not possible to determine with currently available information whether a hospital is located in an urbanized or nonurbanized area.

In summary, we do not believe that urbanized areas offer a viable system for classifying hospitals into core and ring areas because of the unstable nature of the boundaries of urbanized areas, the lag in updating urbanized areas because of the decennial census, and the inherent difficulties in determining whether a hospital is located within an urbanized area.

• Rural Hospitals—As with urban hospitals, although subdividing rural labor market areas according to urbanized and nonurbanized rural areas may increase the explanatory power of the wage index, such partition could also result in additional areas with only a few hospitals, creating for these hospitals a virtual pass through of Medicare-associated labor costs. Also, many of the high-wage rural hospitals mentioned in ProPAC's analysis are rural referral centers, which already receive the urban payment rate. In fact, analysis already indicates that large rural teaching hospitals (many of which are referral centers) are not as costly as their urban counterparts. This suggests that, even absent revisions in labor market definitions, it is appropriate to reduce the urban rate for rural referral centers. See section V.E.4. of this document for our specific proposal in this regard.

Further, we note that the ProPAC analysis of labor areas does not take into consideration the change in methodology required by section 9302(c) of Pub. L. 99-509, that is, computing the average standardized amounts on a discharge-weighted basis rather than on a hospital-weighted basis. We must also take into account those refinements that have already been made to the system in order to improve its equity, and how those refinements, as well as other adjustments, interact with the proposed change. For example, differential outlier offsets to the standardized rates and a reduction in the proportion of hospital costs considered to be labor-related are two changes already implemented that have increased payments to rural hospitals.

Since the factors that make up a hospital's payment are interdependent, a change in the calculation of one factor has an impact on other factors. For this reason, we believe that any analysis of redefined labor markets must be considered in the context of the payment effects to hospitals. It is not sufficient to define an improved wage index merely in terms of that index's ability to explain a greater amount of variation in hospital costs.

Further, ProPAC's recommendation does not take into account the impact of restandardization of the average costs of each hospital in the data base to reflect reconfiguration of the wage index along the lines proposed by ProPAC. In order to avoid creating overpayments and underpayments in the impact model, the same wage index, revised to reflect redefined labor market areas, must be used both in standardizing for area wage differences and in modeling payments.

In our research on the urban and rural differentials in prospective payments, we have examined the impact of alternative wage indexes and labor market areas. Overall, these alternatives produce only a marginal or modest change in prospective payments by equalizing hospital profit margins to some degree. However, it is unclear whether the redistributive effects of alternative labor market areas are appropriate. For example, an urban core-ring system would increase payments to core urban hospitals, which are generally already doing well under the prospective payment system, and decrease payments to suburban ring hospitals. Along with payment redistributions that may not be appropriate, increasing the number of labor market areas would increase both the number of boundaries in the system, thereby also increasing the number of hospitals that would consider themselves unfairly disadvantaged with respect to their location near a particular boundary.

In summary, we appreciate the work invested by ProPAC in examining labor market alternatives. However, at this point, we believe that we are still not knowledgable enough about the effects of these and other alternatives to be able to definitely recommend a particular methodology or classification system.

2. Improving the Area Wage Index (Recommendation No. 13)

Recommendation: The Secretary should update on a regular basis the

hospital wage data necessary for calculating the area wage index. This updated information should include data on the wages and hours of employment for hospital occupational categories.

Response: We have obtained 1984 wage data, and we are proposing in this document an updated blended wage index for FY 1988, which uses these data. These data are not broken down by occupational category.

We are currently in the process of collecting wage data that reflects occupational mix. However, use of this data must await evaluation and analysis.

In principle, we agree with ProPAC that the hospital wage index should be updated on a regular basis. At present, we do not have a process in place for obtaining the necessary data on a regular basis. However, we will be investigating the necessity and feasibility of such a process for further updates.

3. Extension of Volume Protection to All Isolated, Rural Hospitals (Recommendation No. 14)

Recommendation: The Secretary should seek legislation to expand the eligibility for a prospective payment system volume adjustment to all isolated rural hospitals that meet the criteria for sole community hospital status. Eligibility should not be limited to those that have obtained such status in order to maintain 75 percent hospital-specific payments. This legislation is necessary to protect those isolated rural hospitals that are not sole community hospitals, but that are at risk for the effects of reductions in their patient loads.

Response: We are unsure of the extent of the problem identified by ProPAC. We are evaluating whether or not to seek the legislation recommended by ProPAC or alternative legislation addressing the needs of small isolated rural hospitals. Since we do not know the extent of the problem, it is not clear that an adjustment for volume decline would be a satisfactory solution.

4. Clarification of Sole Community Hospital Volume Exception Criteria (Recommendation No. 15)

Recommendation: Before FY 1988 begins, the Secretary should issue instructions for implementing the sole community hospital volume adjustment that clarify the interpretation of the criteria used to grant such an adjustment. The application process for a volume adjustment should be simplified.

Response: We agree that clarifying program instructions for seeking protection from volume declines are necessary. We have drafted an appropriate instruction and will attempt to expedite clearance and issuance of this document.

Given the current statutory language, we believe that the adjustment process cannot be simplified We cannot grant adjustments without evidence to demonstrate that the volume decline was beyond the hospital's control and to identify the fixed costs of necessary core staff and services.

We are proposing, however, to clarify the regulations at § 412.92(e) by stipulating that a volume adjustment will not be approved if a hospital reports positive Medicare operating margins in the cost reporting period for which an adjustment is requested. (Positive margins would be defined as the excess of prospective payments over the hospital's Medicare inpatient operating costs.) Also, we are proposing to amend the regulations to revise the requirement that the volume decline be due to "extraordinary" circumstances beyond the hospital's control. The statute does not require the circumstances to be extraordinary, but only beyond the control of the hospital. (For a detailed discussion of this revision of the regulations, see section V.D. of this preamble.)

5. Evaluation of Current Prospective Payment System Payment Policies for Rural Hospitals (Recommendation No. 16)

Recommendation: The Secretary should complete the studies mandated by Congress in the original prospective payment system and subsequent deficit reduction legislation and make them publicly available as soon as possible. The study on the feasibility and impact of eliminating or phasing out separate urban and rural DRG prospective payment rates should reflect analyses based on first-year prospective payment system Medicare cost reports, and, if possible, preliminary findings from the second year of the prospective payment system. The study of sole community hospitals should be supplemented by an evaluation of the appropriateness of current Medicare payment policies for all small, isolated rural hospitals. The Commission also intends to examine these issues and will share its findings with Congress and the Secretary as they are developed.

Response: Three draft reports mandated by Congress on rural hospital issues are in the process of being prepared. Two of the reports cover specific issues related to sole community hospitals and rural referral centers. The third report is more general and covers several issues relating to the prospective payment system, including separate urban and rural payment rates.

C. Beneficiary Concerns

Concern for beneficiary welfare continues to be of major importance to ProPAC. In this year's report, ProPAC addresses two specific issues, one financial and one related to quality, for which improvements in beneficiary welfare under the prospective payment system may be accomplished.

1. Inpatient Hospital Cost-Sharing Requirements (Recommendation No. 18)

Recommendation: The proportion of inpatient hospital payments borne by Medicare beneficiaries should be returned to its pre-prospective payment system level. This proportion has inappropriately increased as a result of significant declines in length of stay experienced since the beginning of the prospective payment system. Furthermore, the structure of inpatient hospital cost-sharing requirements should be consistent with the prospective payment system incentives. In particular, current coinsurance and spell of illness requirements need to be reexamined.

Response: Section 9301 of Pub. L. 99-509 made a number of changes in the computation of the inpatient hospital deductible in order to make it more consistent with the current payment system. (For additional discussion of this provision, see the notice published in the **Federal Register** on November 20, 1986 (51 FR 42007).) In addition, the Department's recent catastrophic health proposal would further restructure the benefit package and modify beneficiary cost-sharing provisions.

2. Evaluating the Results of PRO Quality of Care Review (Recommendation No. 19)

Recommendation: The Secretary should promptly initiate a comprehensive evaluation of PRO quality of care review activities and findings. The evaluation should assess the impact on quality of care of preadmission, admission, transfer, and readmission review activities. The PRO findings concerning quality of the services furnished during an admission and the health outcome of the episode of care should also be evaluated. ProPAC is aware that the Super-PRO is auditing and validating PRO review activities. However, ProPAC does not believe that this effort can substitute for a comprehensive evaluation of the extent to which PROs are identifying,

assessing, and correcting problems related to quality of care.

Response: We have an extensive and comprehensive system in place to evaluate the credibility of PRO review decisions, including those related to quality of care. ProPAC does not consider the "Super-PRO" evaluation of PRO medical determinations to be sufficient to monitor PRO findings. We agree that the "Super-PRO" alone is not sufficient. However, if the "Super-PRO" results are viewed in the context of other evaluation activities, we believe that we are adequately assessing PRO performance in the area of quality of care review. We believe ProPAC's recommendation would result in a duplicative evaluation effort.

D. Patient Classification and Case Mix

1. Improving the Measurement of Hospital Case Mix (Recommendation No. 20)

Recommendation: ProPAC continues to believe that the DRG system is the most appropriate measure of hospital case mix for the Medicare prospective payment system. The Secretary, however, should improve the measurement of case mix to better account for variations in resource use. In the short term, the Secretary should adopt refinements to the DRG system that make better use of currently available patient data. In the long term, however, it may be necessary to develop improvements based on additional sources of patient information not currently available from the discharge abstract.

Response: We agree with ProPAC's affirmation that the DRG system is the most appropriate measure of hospital case mix on which to base Medicare prospective payments to hospitals. We will continue to pursue research aimed at improving the measurement of case mix to better account for variation in resource use. This research program encompasses both projects using currently available patient data and projects that include additional data. A synopsis of findings to date is included in a report to Congress that is presently under review.

We further agree with ProPAC that, in the short term, refinements to the DRG system will necessarily be based on currently available data. We are proposing changes to the DRG classification system effective for FY 1988 in a separate notice, as discussed in section II of this preamble. We are continuing to pursue research in this area. We also agree with ProPAC that, in the long term, it may become necessary to develop improvements based on additional sources of patient information not currently available from the discharge abstract, and we are actively pursuing research in this area, also.

We believe that improved case-mix measures may be of as great importance for measuring quality of care as for refining hospital payment. Accordingly, we are coordinating research in this area to assure that any proposed systems will serve both goals.

2. Updating the Surgical Hierarchies and the List of Operating Room Procedures (Recommendation No. 23)

Recommendation: The Secretary should evaluate the surgical hierarchies periodically. They should be updated to determine both the clinical appropriateness and resource intensity of the procedures within each class and the relative order of the modified surgical classes. This assessment is necessary to ensure that the hierarchies accurately reflect the relative resource intensity of each operating room procedure. This update process should include clinical input from a broad range of clinicians, including physicians, operating room nurses, medical record experts, and other health care professionals.

Response: We support this recommendation from the standpoint of annual review and revision of the surgical hierarchies and are proposing revision of the hierarchy based on FY 1986 data as set forth in section II.C. of this preamble. While we believe clinical input is valuable from the standpoint of examining the clinical homogeneity of a group of procedures, we are not persuaded that the ordering of procedure groups should be determined by clinicians. The hierarchy is a ranking of DRG procedure groups based on hospital resource intensity. The fact that a given procedure may be more difficult or time-consuming for a physician does not necessarily mean it should be ranked above other procedure groups that require less skill but require more hospital resources.

E. DRG Classification and Weighting Factors

Additional Payment for Magnetic Resonance Imaging (MRI) Scans (Recommendation No. 27)

Recommendation: For a three-year period, Medicare should pay hospitals an additional amount to reflect operating costs for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a prospective payment hospital. The add-on payment should be calculated by the Secretary each year to reflect both changes in the average cost of an efficiently produced scan and the degree to which MRI substitutes for other hospital procedures.

Response: We recognize ProPAC's concern that the current payment methodology may act as a disincentive to the widespread use of MRI technology. However, we regard this concern as anticipatory, since there is no evidence that hospitals furnishing MRI are losing money under the prospective payment system. On the contrary, the hospitals most likely to be furnishing MRI services are urban teaching hospitals; that is, the institutions that have been faring the best under the prospective payment system. We have always held that one of the basic tenets of a system built on averages is that payments would not cover costs in all cases and that excess payments on some cases would offset losses in other cases.

We are concerned that there will be numerous technological advances in the future that would be similar to MRI; that is, several DRGs would be affected by the changes. If we begin to unbundle the prospective payment rate to provide add-on payments in that manner, the basic concept of prospective payments on a discharge basis would be undermined.

We are, however, giving the issue further study. Unique ICD-9-CM codes for MRI services were approved effective October 1, 1986. From this data, we will be able to evaluate the issue more thoroughly in the upcoming months. If we find that the current prospective payment methodology adversely affects the quality of care, we will consider alternative payment options, including add-ons.

F. Research on Case-Mix Change

Record Reabstraction Study (Recommendation No. 28)

Recommendation: The Secretary should initiate, as soon as possible, a study of case-mix change based on a reabstraction of medical records of prospective payment patients. The study should evaluate DRG assignment to distinguish case-mix increases caused by changes in coding practices from changes in treatment patterns and patient mix. The study should serve as the basis on which to develop and refine alternative ongoing data collection methods to monitor case-mix change over time. ProPAC will contribute resources to designing, financing, and monitoring this study.

Response: We agree with ProPAC that a study at the case level that can both distinguish causes for case-mix change and provide the basis for monitoring case-mix change over time is relevant. Accordingly, we intend to collaborate with ProPAC on feasibility studies. We remain concerned, however, that the resources required to undertake a major record reabstraction study are greater than the benefits that would accrue. We are therefore not committing ourselves to undertaking the full study.

VII. Other Required Information

A. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the "Dates" section of this preamble and respond to those comments in the preamble to that rule. We emphasize that, given the statutory requirement under section 1886(e)(5)(B) of the Act that our final rule for FY 1988 be published by September 1, 1987, we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

B. Paperwork Reduction Act

The proposed rule does not impose information collection requirements. Consequently, it need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3511).

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Health facilities, Medicare.

42 CFR Part 413

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 466

Competitive medical plans (CMPs), Grant programs-health, Health care, Health facilities, Health maintenance organizations (HMOs), Health professions, Peer Review Organizations.

42 CFR Chapter IV would be amended as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Subchapter B—Medicare Programs

I. Part 405, Subpart E is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians

A. The authority citation for Subpart E continues to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1842 (b) and (h), 1861 (b) and (v), 1862(a)(14), 1866(a), 1871, 1881, 1886, 1887, and 1889 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395u (b) and (h), 1395x (b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww, 1395xx, and 1395zz).

§ 405.553 [Amended]

B. In § 405.553, in paragraph (b)(4), the phrase "a cost reporting period beginning on or after October 1, 1984 and before October 1, 1987." is revised to read "cost reporting periods beginning on or after October 1, 1984 through cost reporting periods or any part of a cost reporting period, ending before January 1, 1989.".

II. Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

A. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102, 1122, 1871, and 1886 of the Social Security Act, as amended (42 U.S.C. 1302, 1320a–1, 1395hh, and 1395ww).

B. Subpart A is amended as follows:

Subpart A—General Provisions

§ 412.1 [Amended]

1. a. In § 412.1(a), in the third sentence, the phrase "and before October 1, 1987," is revised to read "through cost reporting periods, or any part of a cost reporting period, ending before January 1, 1989,".

b. In § 412.1(b), a new sentence is added at the end of the paragraph to read "Subpart K describes how the prospective payment system is implemented for hospitals located in Puerto Rico."

§ 412.2 [Amended]

2. In § 412.2(d)(5), the phrase "and before October 1, 1987," is revised to read "through cost reporting period, or any part of a cost reporting period, ending before January 1, 1989,".

C. In Subpart B, § 412.23(f) is revised to read as follows:

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment System

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(f) *Hospitals outside the 50 States, the District of Columbia, or Puerto Rico.* A hospital is excluded from the prospective payment system if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

* * * * *

D. Subpart D is amended as follows:

Subpart D—Basic Methodology for Determining Federal Prospective Payment Rates

1. In § 412.60, paragraph (d) is redesignated as paragraph (e), a new paragraph (d) is added, and newly redesignated paragraph (e) is revised to read as follows:

§ 412.60 DRG classification and weighting factors.

* * * * *

(d) *Review of DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews the hospital's request and any additional information and decides whether a change in the DRG assignment is appropriate. If the intermediary decides that a higher-weighted DRG should be assigned, it must request the appropriate PRO to review the case to verify the change in DRG assignment as specified in § 466.70(e)(2) of this chapter.

(3) Following the 60-day period described in paragraph (d)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

(e) *Revision of DRG classification and weighting factors.* Beginning with discharges in fiscal year 1988, HCFA adjusts the classifications and weighting factors established under paragraphs (a)

and (b) of this section at least annually, to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources.

2. In § 412.63, text is added to paragraph (f) to read as follows:

§ 412.63 Federal rates for fiscal years after Federal fiscal year 1984.

* * * * *

(f) *Applicable percentage change for fiscal year 1988.* The applicable percentage change for fiscal year 1988 is the percentage increase in the market basket index (as described in § 413.40(c)(3)(ii)) minus 2.0 percentage points.

* * * * *

E. Subpart E is amended as follows:

Subpart E—Determination of Transition Period Payment Rates

§ 412.71 [Amended]

1. In § 412.71(b)(8), the phrase "October 1, 1984, and before October 1, 1987." is revised to read "on or after October 1, 1984 through cost reporting periods, or any part of a cost reporting period, ending before January 1, 1989."

2. In § 412.73, text is added to paragraph (c)(5) and reserved paragraph (c)(6) is removed to read as follows:

§ 412.73 Determination of the hospital-specific rate.

* * * * *

(c) *Updating base-year costs.*

* * * * *

(5) *For Federal fiscal year 1988 and following.* For purposes of determining the prospective payment rates for sole community hospitals under § 412.92(d), the base-year cost per discharge continues to be updated each Federal fiscal year as follows:

(i) For Federal fiscal year 1988, the update factor is the percentage increase in the market basket index (as described in § 413.40(c)(3)(ii)) minus 2.0 percentage points.

(ii) For Federal fiscal years 1989 and following, the update factor is determined using the methodology set forth in § 412.63(g)(1) through (g)(3).

* * * * *

F. Subpart F is amended as follows:

Subpart F—Payment for Outlier Cases

1. In § 412.82, paragraph (a) is revised; paragraph (d) is redesignated as paragraph (e); and a new paragraph (d) is added to read as follows:

§412.82 Payment for extended length-of-stay cases (day outliers).

(a) Except as specified in paragraph (d) of this section, if the hospital stay reflected by a discharge includes covered days of care beyond the applicable threshold criterion, the intermediary makes an additional payment, on a per diem basis, to the discharging hospital for those days. A special request or submission by the hospital is not necessary to initiate this payment. However, a hospital may request payment for day outliers before the medical review required in paragraph (b) of this section.

* * * * *

(d) The intermediary calculates the hospital's additional payment under the provisions of § 412.84(i) (instead of under the provisions of paragraph (c) of this section) if the hospital stay also qualifies as a cost outlier under the criteria set forth in § 412.80(a)(1)(ii).

* * * * *

§ 412.84 [Amended]

2. a. In § 412.84 (a) and (i), references to "§ 412.80(a)(2)" are revised to read "§ 412.80(a)(1)(ii)".

b. In § 412.84(i), in the first sentence, "60" is revised to read "80".

G. Subpart G is amended as follows:

Subpart G—Special Treatment of Certain Facilities

1. In § 412.92, the introductory text of paragraph (e)(2) is republished and paragraph (e)(2)(ii), the introductory text of paragraph (e)(3), and paragraph (e)(3)(i) are revised to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(e) *Additional payments to sole community hospitals experiencing a significant volume decrease during the transition period.* * * *

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must—

* * * * *

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) HCFA determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue based on DRG-adjusted prospective payment rates (including outlier payments determined under Subpart F of this part and additional payments made for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.118). In determining the adjustment amount, HCFA considers—

(i) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

* * * * *

2. In § 412.96, paragraphs (c)(1), (d), and (e) are revised to read as follows:

§ 412.96 Special treatment: Referral centers.

* * * * *

(c) *Alternative criteria.* * * *

(1) *Case-mix index.* HCFA sets forth national and regional case-mix index values in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology HCFA uses to calculate these criteria is described in paragraph (g) of this section. The case-mix index value to be used for an individual hospital in the determination of whether it meets the case-mix index criteria is that calculated by HCFA from the hospital's own billing records for Medicare discharges as processed by the fiscal intermediary and submitted to HCFA. The hospital's case-mix index for discharges (not including discharges from distinct part units excluded from the prospective payment system under Subpart B of this part) during the Federal fiscal year that ended one year prior to the beginning of the cost reporting period for which the hospital is seeking referral center status must be at least equal to—

* * * * *

(d) *Payment to rural referral centers with 500 or more beds.* A hospital that meets the criteria of § 412.96(b)(1) is paid prospective payments per discharge based on the applicable urban adjusted standardized amounts, as adjusted by the hospital's area wage index. For cost reporting periods beginning on or after October 1, 1987, the applicable urban adjusted standardized amounts are calculated by excluding the costs of hospitals receiving indirect medical education payments as provided in § 412.118.

(e) *Payments to all other rural referral centers.* For cost reporting periods beginning on or after October 1, 1987, a hospital that is located in a rural area and meets the criteria of § 412.96 (b)(2) or (c) is paid prospective payments per discharge based on the applicable urban adjusted standardized amounts calculated by excluding the costs of hospitals receiving indirect medical education payments as provided in

§ 412.118, as adjusted by the hospital's area wage index.

* * * * *

H. In subpart H, § 412.113 is amended as follows:

Subpart H—Payments to Hospitals Under the Prospective Payment System

§ 412.113 [Amended]

In § 412.113(c), the phrase "and before October 1, 1987," is revised to read "through cost reporting periods, or any part of a cost reporting period, ending before January 1, 1989,".

I. A new Subpart K is added to read as follows:

Subpart K—Prospective Payment System for Hospitals Located in Puerto Rico

Sec.

Subpart K—Prospective Payment System for Hospitals Located in Puerto Rico

§ 412.200 General provisions.

Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system. Except as provided in this subpart, the provisions of Subparts A, B, C, F, G, and H of this part apply to hospitals located in Puerto Rico. Except for § 412.60, which deals with DRG classification and weighting factors, the provisions of Subpart D and E, which describe the methodology used to determine prospective payment rates for hospitals, do not apply to hospitals located in Puerto Rico. Instead, the methodology for determining prospective payment rates for these hospitals is set forth in §§ 412.204 through 412.212.

§ 412.204 Payments to hospitals located in Puerto Rico.

Payments to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(a) 75 percent of the Puerto Rico prospective payment rate, as determined under §§ 412.208 or 412.210; and

(b) 25 percent of a national prospective payment rate, as determined under § 412.212.

§ 412.208 Puerto Rico rates for Federal fiscal year 1988.

(a) *General rule.* HCFA determines the Puerto Rico adjusted DRG prospective payment rate for each inpatient hospital discharge occurring in Federal fiscal year 1988 for a prospective payment hospital. These rates are determined as described in paragraphs (b) through (i) of this section.

(b) *Determining target amounts.* For each hospital subject to the prospective payment system, HCFA determines the Medicare target amount, as described in § 413.40(c) of this chapter, for the hospital's cost reporting period beginning in fiscal year 1987. Revisions in the target amounts made subsequent to establishment of the standardized amounts under paragraph (d) of this section do not affect the standardized amounts.

(c) *Updating the target amounts for fiscal year 1988.* HCFA updates each target amount determined under paragraph (b) of this section for fiscal year 1988 by prorating the applicable percentage increase (as defined in § 412.63(f) of this chapter) for fiscal year 1988 to the midpoint of fiscal year 1988 (April 1, 1988).

(d) *Standardizing amounts.* HCFA standardizes the amount updated under paragraph (c) of this section for each hospital by—

(1) Adjusting for variations in case mix among hospitals;

(2) Excluding an estimate of indirect medical education costs;

(3) Adjusting for area variations in hospital wage levels; and

(4) Excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(e) *Computing urban and rural averages.* HCFA computes separate discharge-weighted averages of the standardized amounts determined under paragraph (d) of this section for urban and rural hospitals in Puerto Rico.

(f) *Geographic classifications.* (1) For purposes of paragraph (e) of this section, the following definitions apply:

(i) The term "urban area" means a Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget.

(ii) The term "rural area" means any area outside an urban area.

(2) A hospital classified as rural is deemed to be urban and receives the urban Puerto Rico payment amount if the county in which it is located meets the following criteria:

(i) At least 95 percent of the perimeter of the rural county is contiguous with urban counties.

(ii) The county was reclassified from an urban area to a rural area after April 20, 1983, as described in § 412.62(f)(1)(iv).

(iii) At least 15 percent of employed workers in the county commute to the central county of one of the adjacent MSAs.

(g) *Reducing for value of outlier payments.* HCFA reduces each of the average standardized amounts determined under paragraphs (c) through (e) of this section by a proportion equal to the proportion (estimated by HCFA) of the total amount of payments based on DRG prospective payment rates that are additional payments to hospitals located in Puerto Rico for outlier cases under Subpart F of this part.

(h) *Computing Puerto Rico rates for urban and rural hospitals.* For each discharge classified within a DRG, HCFA establishes a Puerto Rico prospective payment rate, as follows:

(1) For hospitals located in an urban area, the rate equals the product of—

(i) The average standardized amount (computed under paragraphs (c) through (g) of this section) for hospitals located in an urban area; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area, the rate equals the product of—

(i) The average standardized amount (computed under paragraphs (c) through (g) of this section) for hospitals located in a rural area; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(i) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of Puerto Rico rates computed under paragraph (h) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels, by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

§ 412.210 Puerto Rico rates for fiscal years after Federal fiscal year 1988.

(a) *General rule.* (1) HCFA determines the Puerto Rico adjusted prospective payment rate for each inpatient hospital discharge occurring in a Federal fiscal year after fiscal year 1988 that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

(2) The rate is determined for hospitals located in urban or rural areas within Puerto Rico, as described in

paragraphs (b) through (e) of this section.

(b) *Geographic classifications.* For purposes of this section, the definitions set forth in § 412.208(f) apply.

(c) *Updating previous standardized amounts.* HCFA computes separate average standardized amounts for hospitals in urban areas and rural areas within Puerto Rico equal to the respective average standardized amount computed for fiscal year 1988 under § 412.208(e)—

(1) Increased by the applicable percentage change determined under § 412.63(g); and

(2) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments that are additional payment amounts to hospitals located in Puerto Rico attributable to outlier cases under Subpart F of this part.

(d) *Computing Puerto Rico rates for urban and rural hospitals.* For each discharge classified within a DRG, HCFA establishes for the fiscal year a Puerto Rico prospective payment rate as follows:

(1) For hospitals located in an urban area in Puerto Rico, the rate equals the product of—

(i) The average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in an urban area; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area in Puerto Rico, the rate equals the product of—

(i) The average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a rural area; and

(ii) The weighting factor (determined under § 412.60(b)) for that DRG.

(e) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of Puerto Rico rates computed under paragraph (d) of this section that is attributable to wages and labor related costs for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

§ 412.212 National rate.

(a) *General rule.* For purposes of payment to hospitals located in Puerto Rico, the national prospective payment rate is determined as described in paragraphs (b) through (d) of this section.

(b) *Computing a national average standardized amount.* HCFA computes a discharge-weighted average of the—

(1) National urban adjusted standardized amount determined under § 412.63(q)(1)(i); and

(2) National rural adjusted average standardized amount determined under § 412.63(g)(2)(i).

(c) *Computing a national rate.* For each discharge classified within a DRG, the national rate equals the product of—

(1) The national average standardized amount computed under paragraph (b) of this section; and

(2) The weighting factor (determined under § 412.60(b)) for that DRG.

(d) *Adjusting for different area wage levels.* HCFA adjusts the proportion (as estimated by HCFA from time to time) of the national rate computed under paragraph (c) of this section that is attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level

§ 412.220 Special treatment of certain hospitals located in Puerto Rico.

Subpart G of this part sets forth rules for special treatment of certain facilities under the prospective payment system. The following sections in Subpart G of this part do not apply to hospitals located in Puerto Rico:

(a) Section 412.92, sole community hospitals.

(b) Section 412.96, referral centers.

III. Part 413 is amended as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

A. The authority citation for Part 413 continues to read as follows:

Authority: Sections 1102, 1122, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr, and 1395ww).

B. In Subpart C. § 413.40, the introductory text in paragraph (c)(3)(i) is republished and text is added to paragraph (c)(3)(i)(C) to read as follows:

§ 413.40 Ceiling on rate of hospital costs increases.

* * * * *

(c) *Procedure for establishing the ceiling (target amount).*

* * * * *

(3) *Target rate percentage.*

(i) The applicable target rate percentage is determined as follows:

* * * * *

(C) *Federal fiscal year 1988.* The applicable target rate percentage for cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988 is the percentage increase in the market basket index minus 2.0 percentage points.

* * * * *

IV. Part 466, Subpart C is amended as follows:

PART 466—UTILIZATION AND QUALITY CONTROL REVIEW

Subpart C—Review Responsibilities of Utilization and Quality Control Peer Review Organizations (PROs)

A. The authority citation for Part 466 continues to read as follows:

Authority: Secs. 1102, 1154, and 1871 of the Social Security Act (42 U.S.C. 1302, 1320c–3, and 1395hh).

B. In § 466.70, paragraph (e) is amended by redesignating paragraph (e)(2) as (e)(3) and adding a new paragraph (e)(2) to read as follows:

§ 466.70 Statutory bases, applicability and provisions.

* * * * *

(e) *Other duties and functions.*

* * * * *

(2) The PRO must review every change in a DRG assignment that is a result of a review made under the provisions of § 412.62(d) if the change results in the assignment of a higher-weighted DRG and the PRO has not previously reviewed the case. The PRO must verify that the diagnostic and procedural information supplied by the hospital is substantiated by the information in the medical record.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program)

Dated: June 3, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: June 4, 1987.

Otis R. Bowen,

Secretary.

[Editorial Note.—The following addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts Effective With Discharges On or After October 1, 1987, and Update Factors and Target Rate Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1987

I. Summary and Background

In this addendum, we are proposing changes in the methods, amounts, and factors for determining prospective payment rates for Medicare inpatient hospital services. We are also proposing the methods, amounts and factors for determining prospective payment rates for Medicare inpatient hospital services furnished by hospitals in Puerto Rico. Finally, we are proposing new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals and hospital units excluded from the prospective payment system.

For hospital cost reporting periods beginning on or after October 1, 1987, except for sole community hospitals and hospitals located in Puerto Rico, each hospital's payment per discharge under the prospective payment system will, for the first time, be comprised of 100 percent of the Federal rate; that is, hospitals will no longer receive any part of their payment based on a hospital-specific rate (section 1886(d)(1)(A) of the Act). That section of the Act also requires that for discharges occurring on or after October 1, 1987, the Federal portion of a hospital's prospective payment rate is based on 100 percent of the national rate, instead of a blend of regional and national rates.

Sole community hospitals will continue to be paid on the basis of a rate per discharge composed of 75 percent of the hospital-specific rate and 25 percent of the applicable Federal regional rate (section 1886(d)(5)(C)(ii) of the Act).

Effective with discharges occurring on or after October 1, 1987, hospitals in Puerto Rico will be subject to the prospective payment system (section 1886(d)(9) of the Act as added by section 9304(a) of Pub. L. 99-509). However, these hospitals payment per discharge will be the sum of 75 percent of a Puerto Rico rate and 25 percent of a national rate.

As discussed below in section II, we are proposing to make changes in the determination of the prospective payment rates. The changes, to be applied prospectively, would affect the calculation of the Federal rates. Section III sets forth our proposals concerning the determination of payment rates for hospitals in Puerto Rico. In section IV, we discuss the various adjustments made to the average standardized amounts in order to achieve budget neutrality in those areas in which it is required. Section V sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the proposed rule are presented at the end of this addendum.

II. Proposed Changes to Prospective Payment Rates and DRG Weighting Factors for FY 1988

The basic methodology for determining Federal national prospective payment rates is set forth at § 412.63. Below we discuss the manner in which we are proposing to change some of the factors or methodology used for determining the prospective payment rates. The Federal rate changes, once issued as final, would be effective with discharges occurring on or after October 1, 1987.

In summary, we are proposing to establish the FY 1988 national and regional rates (that is, the standardized amounts set forth in Table 1a and 1b of the addendum) by—

- Restandardizing, with the 1982 HCFA wage index, the hospital costs used to establish the rates to reflect the revisions we propose to make in the methodology for calculating the national average hourly wage;
- Computing average costs per case per hospital and adjusting costs per case to exclude the effects of case mix, indirect medical education costs, payment adjustments to disproportionate share hospitals, and cost-of-living differences for Alaska and Hawaii;
- Grouping the adjusted operating costs per case (labor-related and nonlabor-related) to compute urban and rural, national and regional average standardized amounts using averages weighted by total discharges rather than by number of hospitals;
- Updating the standardized amounts by 2.7 percent (that is, the increase in the market basket percentage minus 2.0 percentage points).

A. Calculation of Adjusted Standardized Amounts

1. Standardization and restandardization of base-year costs. Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the interim final rule, published September 1, 1983 (48 FR 39763), contains a detailed explanation of how base-year cost data were established in the initial development of standard amounts for the prospective payment system and how they are used in computing the Federal rates.

Section 1886(d)(2)(C) of the Act required that the updated base-year per discharge costs be standardized in order to remove from the cost data the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments, and indirect medical education costs. We are proposing to restandardize the base-year costs using the 1982 HCFA wage index to reflect the change in the methodology for computing the national average hourly wage.

We are not proposing at this time to restandardize the base-year costs for the following:

- Case mix.
- Indirect medical education costs.
- Cost of living for Alaska and Hawaii.
- Payments to hospitals that serve a disproportionate share of low-income patients.

While the effects of these variables have already been accounted for through standardization, we are evaluating more recent data with respect to payments for indirect medical education costs and payments to hospitals serving a disproportionate share of low-income patients. Depending upon the results of our evaluation, we may restandardize the base-year costs as a part of the final rule to take account of the more recent data.

a. *Adjustments for variation in hospital wage levels.* Section 1886(d)(2)(C)(ii) of the Act requires that for each inpatient hospital discharge in FY 1984 we standardize the average cost per case of each hospital used to develop the separate urban and rural standardized amounts for differences in area wage levels. Therefore, we divided each standardized amount into labor and nonlabor portions, based on the labor and nonlabor components of the hospital market basket, and standardized the labor portion of the FY 1984 standardized amounts using the Bureau of Labor Statistics' (BLS's) area wage index. For FY 1986, we adopted a new wage index based on HCFA survey data and we restandardized the base year costs used to calculate the FY 1986 standardized amounts to account for the new wage index. We removed the effect of the previous standardization for each hospital's BLS wage index by multiplying each hospital's average cost per discharge value by the old index and restandardized the amounts by dividing that result by the new HCFA wage index (see 50 FR 35692).

As discussed in section III of the preamble, we are proposing to use a blended HCFA wage index composed of two separate wage indexes based on 1982 and 1984 data, respectively, and to make a change in the methodology for computing the national average hourly wage, which serves as the basis for indexing the area wage levels. However, the latter change would result in lower index values for all areas relative to the national average hourly wage, since the national average hourly wage based on the 1982 data is higher using the proposed methodology. In order for our proposed change in methodology to have no adverse impact on level of payments to hospitals, the base year costs used to calculate the standardized amounts must be restandardized to take into account the effect on each area's wage index value of the revised methodology for calculating the national average hourly wage.

As discussed in section III of the preamble, section 9103(a) of Pub L. 99-272 gives us the authority to revise the wage index. Since there is an express statutory direction to make periodic adjustments in the wage index, and an adjustment in the calculation of the national average hourly wage cannot properly be implemented unless restandardization also occurs, the "exceptions and adjustments" authority of section 1886(d)(5)(C)(ii) of the Act allows us to restandardize the base year costs to take into account a revised national average hourly wage.

Therefore, we are restandardizing the base year costs that were used to calculate the standardized amounts using the 1982 HCFA wage index. We have removed the effect of the previous standardization (1982 HCFA wage index based on an area-weighted national average hourly wage) by multiplying each hospital's average cost per discharge value by the current 1982 wage index and restandardizing the amount by dividing that result by the 1982 HCFA wage index recalculated using the proposed methodology for computing the national average hourly wage.

It is important to note that recomputing the national average hourly wage for purposes of deriving wage indexes to use in standardizing each hospital's 1981 Medicare cost per discharge results in a uniform increase in each hospital's base year cost per discharge. Without restandardization, each hospital's Medicare cost per discharge, and thus the average standardized amounts, would be too low relative to the wage indexes which would be used to adjust hospital prospective payments to take account of area differences in wages.

b. Variations in case mix among hospitals. Section 1886(d)(2)(C)(iii) of the Act requires that the updated FY 1984 amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (that is, the case-mix index) is explained in the September 1, 1983 interim final rule (48 FR 39768-39771). A case-mix index has been calculated for each hospital based on 1981 cost and billing data.

Standardization, necessary to neutralize inpatient operating costs for the effects of variations in case mix, is accomplished by dividing the hospital's average cost per Medicare discharge by that hospital's case-mix index. Table 3a in the addendum to the September 1, 1983 interim final rule (48 FR 39847-39870) contains the case-mix index values used for this purpose. We are not proposing at this time to make any changes to the case-mix index for inpatient operating costs and, therefore, are not restandardizing the updated amounts for variations in case-mix.

c. Indirect medical education costs. Section 1886(d)(2)(C)(i) of the Act requires that the updated FY 1984 amounts be standardized for indirect medical education costs. Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional payment for the indirect costs of medical education. Section 9104(a) of Pub. L. 99-272 revised section 1886(d)(5)(B) of the Act to reduce the education adjustment factor used to determine the indirect medical education payment from 11.59 percent to approximately 8.1 percent for discharges occurring on or after May 1, 1986 and before October 1, 1988. (Section 9306(c) of Pub. L. 99-509 later amended section 1886(d)(5)(B) of the Act to change the end date of October 1, 1988 to October 1, 1989.) For discharges occurring on or after October 1, 1989, the adjustment factor is equal to approximately 8.7 percent. These factors are approximations because in addition to being reduced, the adjustment factor is no longer applied on a linear basis, but rather on a curvilinear or variable basis. An adjustment made on a curvilinear basis reflects a nonlinear cost relationship, that is, each absolute increment in a hospital's ratio of interns and residents to beds does not result in an equal proportional increase in costs. Therefore, the adjustment factors are only approximately 8.1 percent and 8.7 percent.

For discharges occurring on or after May 1, 1986 and before October 1, 1989, the indirect medical education factor equals the following:

$$2 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.405} - 1\right]$$

For discharges occurring on or after October 1, 1989, the indirect medical education factor equals the following:

$$1.5 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.5795} - 1\right]$$

Section 9104(b) of Pub. L. 99-272 amended section 1886(d)(2)(C)(i) of the Act to provide that the standardized amounts be restandardized to reflect the changes made to the payment adjustment for indirect medical education adjustment under section 9104(a) of Pub. L. 99-272. Therefore, in establishing the standardized amounts used to determine the FY 1987 prospective payment rates, after adjusting each hospital's inpatient operating cost per discharge for inflation, differences in area wage levels, and case mix, we divided each teaching hospital's cost per discharge by 1.0 plus the individual hospital's indirect medical education adjustment factor as

computed using the formula described above, which section 1886(d)(5)(B)(ii)(I) of the Act requires be used for discharges on or after May 1, 1986 and before October 1, 1989. As discussed above, after review of more recent data, we may restandardize the base-year costs as part of the final rule to take into account these later data.

d. Cost-of-living factor for Alaska and Hawaii. Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

Generally, these two States have higher levels of cost in comparison to other States in the nation The high cost of labor is accounted for in the wage index adjustments discussed above. However, the high cost of living in these States also affects the cost of nonlabor items (for example, supplies and equipment). Therefore, in order to remove the effects of the higher nonlabor costs from the overall cost data (that is, for standardization purposes), the nonlabor portion of the average cost per Medicare discharge in hospitals located in Alaska and Hawaii is divided by an appropriate cost-of-living adjustment factor.

e. Costs for hospitals that serve a disproportionate share of low-income patients. Section 9105(b) of Pub. L. 99-272 amended section 1886(d)(2)(C) of the Act by adding a new section 1886(d)(2)(C)(iv) to provide that effective with discharges occurring on or after October 1, 1986 and before October 1, 1988, the updated amounts be standardized for the estimated additional payments made to hospitals that serve disproportionate shares of low-income patients. That is, the law requires us to remove the effects of the payments made to disproportionate share hospitals from the costs used to establish the standardized amounts. Section 9306(c) of Pub. L. 99-509 extended the effective date of the disproportionate share provision to discharges occurring before October 1, 1989. For discharges occurring on or after October 1, 1989, we would no longer make such an adjustment to take into account the estimated payments made to disproportionate share hospitals, since section 1886(d)(5)(F) of the Act does not authorize such payments for discharges after September 30, 1989.

Therefore, in establishing the standardized amounts for FY 1988, we are proposing to adjust each disproportionate share hospital's inpatient operating cost per discharge by adding 1.0 to the applicable disproportionate share payment factor, and dividing the hospital's cost per discharge by that number. In this way we would remove the effect of payment adjustments for disproportionate share hospitals from the standardized amounts as required under section 1886(d)(2)(C)(iv) of the Act.

Under section 1886(d)(5)(F)(vi) calculation of the disproportionate share adjustment factor requires us to calculate the number of a hospital's patient days attributable to Medicare beneficiaries entitled to Supplemental Security Income (SSI), and to non-Medicare beneficiaries eligible for Medicaid. In determining the disproportionate share adjustment factors for purposes of standardizing the standardized amounts, we would use available data on the percentage of Medicaid days from Medicare cost reports with cost reporting periods beginning in Federal FY 1984 and we would use the percentage of SSI/Medicare days for FY 1985 derived from matching FY 1985 SSI eligibility files to Medicare FY 1985 PATBILL records. As discussed above, in the final rule, we may restandardize the base-year costs to take into account more recent payment data.

In accomplishing this standardization, we also have not taken into account any payments to hospitals that qualify for disproportionate share payments based on the percentage of their revenue from State and local government sources for indigent care. This is because these hospitals must demonstrate on a hospital-by-hospital basis that they meet the criteria for a payment adjustment. We do not know at this time how many or which hospitals will ultimately qualify under this provision. While we anticipate that the number of such hospitals will be small, and therefore would not have a significant effect on the standardized rates, we will monitor this situation closely, and, to the extent possible, will present our data and analysis in the final rule. Should a larger number of hospitals than expected qualify, we will consider restandardizing the rates to take account of payments to these hospitals.

We also note that section 9306(a) of Pub. L. 99-509 amended section 1886(d)(5)(F)(v) of the Act to provide that a hospital that is located in a rural area and has 500 or more beds also serves a significantly disproportionate number of low-income patients for a cost reporting period if the hospital has a disproportionate patient percentage that equals or exceeds a percentage specified by the Secretary. We are implementing this revision to the law in a separate rulemaking document. If standardization is necessary to take into account additional payments as a result of that rulemaking, we will do it as part of the final rule. Because we anticipate that the number of additional payments will be small, we expect that there will be little or no impact on the standardized amounts as a result of these additional payments.

2. Grouping of urban/rural averages within geographic areas. Under section 1886(d)(2)(D) of the Act, the average standardized amounts must be determined for hospitals located in urban and rural areas of the nine census divisions and the nation. For FY 1988, the Federal rates will be comprised of 100 percent of the national rate (section 1886(d)(1)(A)(iii) of the Act). Section 1886(d)(5)(C)(ii) of the Act specifies that a sole community hospital's Federal rate is based on 100 percent of the regional rate.

In previous prospective payment proposed and final rules, Table 1 has contained 20 standardized amounts (ten urban amounts and ten rural amounts which are further divided into labor-related and nonlabor-related portions). However, this year we are splitting Table 1 into Tables 1a and 1b. Table 1a would contain the two national standardized amounts that are applicable to most hospitals. Table 1b would set forth the 18 regional standardized amounts applicable to sole community hospitals. The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts, except that the national urban and rural groups include hospitals from all urban and all rural geographic areas, respectively.

Currently, the average standardized amounts are based on hospital-weighted averages; that is, the average standardized amount is the average of the average standardized costs per discharge of all hospitals. As a result, each hospital, regardless of its number of discharges, has an equal impact on the average.

Section 9302(c) of Pub. L. 99-509 amended section 1886(d)(3)(A) of the Act to specify that, with respect to discharges occurring on or after October 1, 1987, urban and rural averages are to be computed on the basis of discharge-weighting rather than hospital-weighting. Under discharge-weighting, the standardized amounts are based on an average derived by dividing total costs by the number of discharges. Thus, a hospital with a high number of

discharges has a correspondingly greater impact on the overall average.

Example:

Hospital	Total costs	No. of discharges	Cost/discharge
A	$30,000	10	$3,000
B	100,000	50	2,000
C	350,000	100	3,500
D	500,000	200	2,500
E	1,600,000	400	4,000
Total	2,580,000	760	15,000

Hospital-weighted average = (Sum of each hospital's cost/discharge) divided by (number of hospitals) = $15,000 divided by 5 = $3,000.

Discharge-weighted average = (Sum of the total costs) divided by (number of discharges) = $2,580,000 divided by 760 = $3,394.74.

The higher discharge-weighted standardized amount ($3,394.74 as opposed to $3,000) can be attributed in large part to the relatively high number of discharges averaging $4,000 per discharge. Section 1886(d)(3)(A) of the Act also specifies that appropriate adjustments are to be made to ensure that average standardized amounts computed on the basis of discharge-weighting do not result in total payments that are greater or less than the total payments that would have been made had the average standardized amounts been computed on the basis of hospital-weighting; that is, this provision must be "budget neutral" (For a detailed discussion of budget neutrality, see section IV of this addendum.)

The Executive Office of Management and Budget (EOMB) may announce revised listings of the Metropolitan Statistical Area (MSA) and New England County Metropolitan Area (NECMA) designations that are used in calculating the standardized amounts. If EOMB makes the announcement before we issue the final rule, we will list the revised MSA/NECMA designations in the addendum to the final rule. The changes in designation will apply beginning in FY 1988. It should be noted, however, that section 526 of the Continuing Appropriations for Fiscal Year 1987 (See Pub. L. 99-500, enacted on October 18, 1986 and Pub. L. 99-591, October 30, 1986) changed the designation of the Wichita, Kansas MSA to include Harvey County, Kansas. The proposed wage index, as well as the standardized amounts included in this proposed rule, incorporate this change, which would be effective October 1, 1987 for prospective payment purposes.

3. Updating the average standardized amounts. In accordance with section 1886(d)(3)(A) of the Act as amended by section 9302(a)(2) of Pub. L. 99-509, we are proposing to update the urban and rural average standardized amounts using the applicable percentage increase specified in section 1886(b)(3)(B) of the Act, as amended by section 9302(a)(1) of Pub. L. 99-509. The percentage increase to be applied is mandated under that section of the law as the estimated increase in the hospital market basket percentage minus 2.0 percentage points. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care.

In the September 3, 1986 final rule, we revised the hospital market basket by rebasing to reflect 1982, rather than 1977, cost data, expanding the number of market basket cost categories from 18 to 28, and modifying certain variables used as the price proxies for some of the cost categories. For a detailed discussion of this revision, see 51 FR 31461-31468.

The most recent forecasted hospital market basket increase for FY 1988 is 4.7 percent. Therefore, the applicable percentage increase is 2.7 percent (market basket percentage increase minus 2.0 percentage points). Thus, we are proposing that the standardized amounts and the hospital-specific rates (which for cost reporting periods beginning on or after October 1, 1987 apply only to sole community hospitals) be increased by 2.7 percent.

Although the update factor for FY 1988 is set by law, we were required by section 1886(e)(3)(B) of the Act to report to Congress no later than April 1, 1987 on our initial estimate for an update factor for FY 1988 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included this report as Appendix B of this proposed rule. Our proposed recommendation on the update factor, as well as our responses to ProPAC's recommendations concerning the update factor, will be published in a separate **Federal Register** document.

4. Other adjustments to the average standardized amounts— a. Part B costs. Section 1862(a)(14) of the Act prohibits payments for nonphysician services furnished to hospital inpatients unless the services are furnished either directly by the hospital, or by an entity under arrangements made by the hospital under which Medicare's payment to the hospital discharges the beneficiary's liability to pay for the services furnished.

In the September 3, 1985 final rule, we increased the average standardized amounts by 0.13 percent so that they represent costs previously billed under Part B (50 FR 35708). In the September 3, 1986 final rule, we stated that we were making no further adjustments for this factor in FY 1987, or in future Federal fiscal years, because the appropriate adjustment had been built into the FY 1986 base (51 FR 31521).

b. FICA taxes. Section 1886(b)(6) of the Act requires that adjustments be made in the base period costs in recognition of the fact that certain hospitals were required to enter the Social Security system and begin paying FICA taxes as of January 1, 1984. In the September 3, 1985 final rule, we increased the average standardized amounts by 0.18 percent to account for additional costs of payroll taxes for hospital entering the Social Security system (50 FR 35708). In the September 3, 1986 final rule we stated that we were making no further adjustments for this factor in FY 1987, or in future Federal fiscal years, because the appropriate adjustment has also been built into the FY 1986 base.

c. Nonphysician anesthetist costs. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1, 1989 and struck subsection (E) effective on that date.

In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall budget neutrality adjustment (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we are not proposing to make further adjustments to the average standardized amounts for FY 1988.

d. Indirect medical education. Section 9104(b) of Pub. L. 99-272 added section 1886(d)(3)(C)(ii) to the Act to provide that, effective for discharges occurring

on or after October 1, 1986, the average standardized amounts be further reduced, taking into consideration the effects of the standardization for indirect medical education costs as described in section II.A.1.c. of this addendum. Specifically, for each geographic area (regional and national, urban and rural), total payments including indirect medical education and disproportionate share hospital adjustments, based on payment rates standardized for an 8.1 percent curvilinear indirect medical education factor and for disproportionate share, shall be neither more nor less than the estimated total of payments, including indirect medical education adjustment payments that would have been made based on rates standardized for an 11.59 percent linear indirect medical education factor and paid out at 8.7 percent on a curvilinear basis. The adjustment is accomplished on a regional basis in order to reflect congressional intent that the necessary calculations will not redistribute payments among the regions. Through this adjustment, Congress is ensuring that total prospective payments, on a regional basis, taking into consideration the restandardization of rates for disproportionate share payments and for a revised indirect medical education payment factor of approximately 8.1 percent on a curvilinear basis, will equal payments that would have resulted with rates standardized for an 11.59 percent indirect medical education adjustment factor, and payments computed using an indirect medical education factor of 8.7 percent applied on a curvilinear basis For discharges on or after October 1, 1989 (that is, after that part of the law requiring disproportionate share payments ceases to be in effect), the adjustment must be such as to ensure that the system savings resulting from the changes to the indirect medical education factor are preserved.

Therefore, under section 1886(d)(3)(C)(ii) of the Act, for FY 1988 we are proposing to adjust the urban and rural regional and national standardized amounts to account for indirect medical education payments. This adjustment has been made in conjunction with the budget neutrality adjustments (see section IV of this addendum).

f. Outliers. Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(3)(B) of the Act correspondingly requires that the standardized amounts be reduced by the proportion of estimated total DRG payments attributable to estimated outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act further directs that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made based on the prospective payment rates in any year.

In the September 3, 1986 final rule, we set the outlier thresholds so as to result in estimated outlier payments equal to five percent of total prospective payments (that is, estimated outlier payments plus regular prospective payments per discharge, excluding indirect medical education payments and disproportionate share hospital payments) for FY 1987 (51 FR 31523).

Section 9302(b)(1) of Pub. L. 99-509 amended section 1886(d)(3)(B) of the Act to require that, effective with discharges occurring on or after October 1, 1986, each national and regional standardized amount be reduced for hospitals located in urban areas and for hospitals located in rural areas based on the estimated proportion of total DRG payments attributable to outlier payments for hospitals in urban areas and for hospitals in rural areas, respectively. Consequently, instead of the uniform five percent reduction factor applying equally to all the standardized amounts, there are now two separate reduction factors, one applicable to the urban national and regional standardized amounts and the other applicable to the rural national and regional standardized amounts. Rates for urban hospitals, which are projected to receive outlier payments in excess of five percent of total DRG payments, are reduced by that larger percentage (instead of by five percent). Rates for rural hospitals, which are projected to receive outlier payments of less than five percent of total DRG payments, are reduced by the lower percentage (instead of by five percent).

In addition, section 9302(b)(3) of Pub. L. 99-509 requires that for discharges occurring in FY 1987 the separate outlier offset provisions in section 9302(b)(1) of Pub. L. 99-509 for urban and rural hospitals result in a reduction of the standardized amounts for outlier payments that is at the same level as if the provision had not been enacted.

The outlier adjustment factors for FY 1987 were as follows:

OUTLIER REDUCTION FACTORS

Urban	Rural
.94632	.97820

We are proposing to continue to set the outlier thresholds so as to result in estimated outlier payments equal to five percent of total prospective payments. Therefore, for FY 1988, we would set the day outlier threshold at the lesser of 23 days or 2.0 standard deviations and the cost outlier threshold at the greater of 2.0 times the prospective payment rate for the DRG or § 16,000.

The proposed outlier adjustment factors for FY 1988 are as follows:

OUTLIER REDUCTION FACTORS

Urban	Rural
.94519	.97246

B. Adjustments for Area Wage Levels and Cost-of-Living

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the intermediaries in determining the prospective payment rates as described in section D below. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Tables 1a and 1b, as we propose in this addendum, contain the actual labor-related and nonlabor-related shares that would be used to calculate the prospective payment rates for hospitals located in the 50 States and the District of Columbia.

1. Adjustment for area wage levels. Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of the preamble to this proposed rule, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a and 4b of this addendum.

2. Adjustment for cost of living in Alaska and Hawaii. Section 1886(d)(5)(C)(iv) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States were included in the adjustment for area wages above. For FY 1988, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and

Hawaii would be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
Oahu	1.225
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.15

(The above factors are based on data obtained from the U.S. Office of Personnel Management)

C. DRG Weighting Factors

As discussed in section II of the preamble to this proposed rule, we have developed a classification system for all hospital discharges, sorting them into DRGs, and have developed weighting factors for each DRG that are is intended to reflect the relative average resource consumption associated with each DRG.

Table 5 of section VI of this addendum contains the weighting factors that we propose to use for discharges occurring in FY 1988. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 1988; General Formula for Calculation of Prospective Payment Rates for Cost Reporting Periods Beginning on or After October 1, 1987 and Before October 1, 1988

Prospective Payment Rate for all hospitals except sole community hospitals=Federal Portion.

Prospective Payment Rate for Sole Community Hospitals=75 percent of the hospital-specific portion+25 percent of the Federal portion.

Federal portion. For cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988, except for sole community hospitals, 100 percent of the hospital's rate is the hospital's Federal rate. Beginning with discharges occurring on or after October 1, 1987, the Federal rate is comprised of 100 percent of the Federal national rate except for sole community hospitals, whose 25 percent Federal portion is based on the Federal regional rate The Federal rates are determined as follows:

Step 1—Select the appropriate regional or national adjusted standardized amount considering the type of hospital and urban and rural designation of the hospital (see Tables 1a and 1b, section VI of this addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Sum the amount from step 2 and the nonlabor portion of the standardized amount (adjusted if appropriate under step 3).

Step 5—Multiply the final amount from step 4 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section VI of this addendum).

2. Hospital-specific portion (applicable only to sole community hospitals). The hospital-specific portion of the prospective payment rate is based on a hospital's historical cost experience. For the first cost reporting period under prospective payment, a hospital-specific rate was calculated for each hospital, derived generally from the following formula:

$$\frac{\text{Base year costs per discharge}}{\text{1981 case-mix index}} \times \text{updating factor} = \text{Hospital-specific rate}$$

For sole community hospitals, the hospital-specific portion equals 75 percent of the hospital-specific rate for all cost reporting periods beginning on or after October 1, 1983. For each subsequent cost reporting period, the hospital-specific portion is derived as follows: Hospital-Specific Rate×Updating Factor×Blending Percentage×DRG Weight.

For a more detailed discussion of the hospital-specific portion, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772).

a. Updating the hospital specific rates for FY 1988 cost reporting periods. We are proposing to increase the hospital-specific rates by 2.7 percent (market basket percentage increase minus two percentage points) for cost reporting periods beginning on or after October 1, 1987. As required by sections 1886(b)(3)(A) and (B) of the Act (as amended by section 9302 of Pub. L. 99-509), this is the same percentage increase (2.7 percent) by which we are proposing to change the Federal rates for FY 1988.

b. Calculation of hospital-specific portion. For sole community hospital cost reporting periods beginning on or after October 1, 1987, the hospital-specific portion of a hospital s payment for a given discharge would be calculated by—

Step 1—Multiplying the hospital's hospital-specific rate by the applicable update factor (1.027);

Step 2—Multiplying the result in Step 1 by 75 percent; and

Step 3—Multiplying the amount resulting from Step 2 by the specific DRG weighting factor applicable to the discharge. The result is the hospital-specific portion of the FY 1988 prospective payment for a given discharge for a sole community hospital.

III. Prospective Payment Rates For Hospitals Located in Puerto Rico

This section contains an explanation of how we propose to derive the adjusted standardized payment amounts applicable for FY 1988 for hospitals located in Puerto Rico. The methodology for arriving at the appropriate rate structure is essentially prescribed by section 1886(d)(9) of the Act and is set forth in regulations in proposed §§ 412.207 through 412.212.

A. Calculation of Adjusted Standardized Amounts

The proposed Puerto Rico adjusted standardized amounts, which are set forth in Table 1c, would be computed as described below.

1. Target amounts. Section 1886(d)(9)(B)(i) of the Act requires that we determine the Medicare target amount (as defined in section 1886(b)(3)(A) of the Act) for each hospital for its cost reporting period beginning in FY 1987. For purposes of computing the Puerto Rico standardized amounts, we will not consider revisions to the target amounts subsequent to HCFA s development of those amounts.

2. Updating for FY 1988. Section 1886(d)(9)(B)(i) of the Act also requires that each target amount be updated to the midpoint of FY 1988 (April 1, 1988) by prorating the applicable percentage increase for FY 1988 as defined in section 1886(b)(3)(B) of the Act. That section of the Act specifies that the applicable percentage increase for FY 1988 is the increase in the market basket percentage minus 2.0 percentage points, that is, 2.7 percent.

3. Standardization of the target amount. Section 1886(d)(9)(B)(ii) of the Act requires that the updated target amount for each hospital be standardized for several variables. Standardization means the removal of the effects of certain sources of

variation in cost among hospitals. These include case mix, differences in area wage levels, payments for hospitals that serve a disproportionate share of low-income patients, and indirect medical education costs.

a. Adjustments for variations in hospital wage levels. Section 1886(d)(9)(B)(ii)(II) of the Act requires that the updated target amount be standardized by adjusting for variations among hospitals by area in the average area hospital wage level. Therefore, the target amount is divided into labor and nonlabor portions, based on the labor and nonlabor components of the hospital market basket. The labor-related portion is then divided by the appropriate wage index for the geographic area in which the hospital is located to remove the effects of local wage differences from hospital target amounts.

As discussed in section III of the preamble, we are proposing to update the HCFA wage index using 1984 data and to make a change in the methodology for computing the national average hourly wage, which serves as the basis for indexing the area wage levels. In addition, as discussed in section IV of the preamble, we are adding wage index values for areas in Puerto Rico to the wage index. The wage index is set forth in Tables 4a and 4b.

b. Variations in case mix among hospitals. Section 1886(d)(9)(B)(ii)(III) of the Act requires that the updated target amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (that is, the case-mix index) is explained in the September 1, 1983 interim final rule (48 FR 39768–39771). A case mix index has been calculated for each hospital in Puerto Rico based on 1984 data.

Standardization, necessary to neutralize inpatient operating costs for the effects of variations in case mix, is accomplished by dividing the hospital's average cost per Medicare discharge by that hospital's case-mix index.

c. Indirect medical education costs. Section 1886(d)(9)(B)(ii)(I) of the Act requires that the updated target amounts be standardized for indirect medical education costs. Section 1886(d)(9)(D)(ii) of the Act provides that prospective payment hospitals in Puerto Rico receive an additional payment for the indirect costs of medical education as specified in section 1886(d)(5)(B) of the Act. Under section 1886(d)(5)(B) of the Act, the indirect medical education cost payment is based on an education adjustment factor, which is approximately 8.1 percent for discharges occurring on or after May 1, 1986 and before October 1, 1989. For discharges occurring on or after October 1, 1989, the adjustment factor is equal to approximately 8.7 percent. These factors are approximations because, as shown below, the adjustment factor is calculated on a curvilinear or variable basis. An adjustment made on a curvilinear basis reflects a nonlinear cost relationship, that is, each absolute increment in a hospital' s ratio of interns and residents to beds does not result in an equal proportional increase in costs. Therefore, the adjustment factors are only approximately 8.1 percent and 8.7 percent.

For discharges occurring on or after May 1, 1986 and before October 1, 1989, the indirect medical education factor is calculated using the following formula:

$$2 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.405} - 1\right]$$

For discharges occurring on or after October 1, 1989, the indirect medical education factor equals the following:

$$1.5 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.5795} - 1\right]$$

Therefore, after adjusting each hospital's updated target amount for differences in area wage levels and case mix, we divided each teaching hospital's target amount by 1.0 plus the individual hospital's indirect medical education adjustment factor as computed using the formula described above, which section 1886(d)(5)(B)(ii)(I) of the Act requires be used for discharges on or after May 1, 1986 and before October 1, 1989.

d. Costs for hospitals that serve a disproportionate share of low-income patients. Section 1886(d)(9)(B)(ii)(IV) of the Act provides that the updated target amounts be standardized for the estimated additional payments made to hospitals that serve disproportionate shares of low-income patients. That is, the law requires us to remove the effects of the payments made to disproportionate share hospitals from the costs used to establish the standardized amounts.

Therefore, we are proposing to adjust each disproportionate share hospital's updated target amount by adding 1.0 to the applicable disproportionate share payment factor, and dividing the hospital's updated target amount by that number. In this way, we would remove the effect of payment adjustments for disproportionate share hospitals from the standardized amounts as required under section 1886(d)(9)(B)(ii)(IV) of the Act.

In determining the disproportionate share adjustment factors for purposes of standardizing the updated target amounts, we would use available data on the percentage of Medicaid days from FY 1984 Medicare cost reports and the percentage of SSI/Medicare days for FY 1985 derived from matching FY 1985 SSI eligibility files to Medicare FY 1985 PATBILL records.

In accomplishing this standardization, we have not taken into account any payments to hospitals that qualify for disproportionate share payments based on the percentage of their revenue from State and local government sources for indigent care. This is because these hospitals must demonstrate on a hospital-by-hospital basis that they meet the criteria for a payment adjustment. We do not know at this time how many or which hospitals will ultimately qualify under this provision. While we anticipate that the number of such hospitals will be small, and therefore would not have a significant effect on the standardized rates, we will monitor this situation closely, and, to the extent possible, will present our data and analysis in the final rule. Should a larger number of hospitals than expected qualify, we will consider

restandardizing the rates to take account of payments to these hospitals.

4. Grouping of urban/rural averages within geographic areas. Under section 1886(d)(9)(B)(iii) of the Act, the average standardized amount per discharge must be determined for hospitals located in urban and rural areas in Puerto Rico. That section of the Act also specifies that the urban and rural average standardized amounts for Puerto Rico hospitals are based on discharge-weighted averages just as section 1886(d)(3)(a) of the Act specifies this methodology for the average standardized amounts that are applicable to other prospective payment hospitals. This methodology is discussed in detail in section II.A.2. of this addendum. The proposed average standardized amounts for hospitals located in Puerto Rico are set forth in Table 1c.

EOMB may announce revised listings of the MSA designations that are used in calculating the standardized amounts for Puerto Rico. If EOMB makes the announcement before we issue the final rule, we will list the revised MSA designations in the addendum to the final rule. The changes in designation will apply beginning in FY 1988.

5. Other adjustments to the average standardized amounts. The average standardized amounts, calculated as described above, would be further adjusted as explained below. Note that there is no adjustment for Part B costs or FICA taxes as there is for prospective payment hospitals located outside of Puerto Rico. This is because adjustments to account for these costs have already been made to the target amounts on which the average standardized amounts are based.

a. Nonphysician anesthetist costs. Section 1886(d)(9)(D)(iv) of the Act specifies that the provisions of section 1886(d)(5)(E) of the Act apply to hospitals located in Puerto Rico. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1, 1989 and struck subsection (E) effective on that date.

We considered the effect of the pass-through provision on the average adjusted standardized amounts as part of the budget neutrality analysis (see discussion in section IV of this addendum).

b. Outliers. Section 1886(d)(5)(A)(iv) of the Act, made applicable to Puerto Rico by section 1886(d)(9)(D)(i) of the Act, directs that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made to prospective payment hospitals based on the payment rates in any year. Since Puerto Rico hospitals will be subject to the prospective payment system beginning October 1, 1987, bills from those hospitals have been used in setting the proposed outlier thresholds (set forth above in section II.A.4.f. of the addendum) so that overall system-wide outlier payments are estimated to be five percent of total prospective payments as required by law.

Section 1886(d)(3)(B) of the Act requires that separate urban and rural outlier offsets to the standardized amounts be developed. As initially implemented October 1, 1986, these offsets apply on a national basis to urban and rural hospitals. However, section 1886(d)(9)(B)(iv) of the Act requires that the urban and rural standardized amounts be reduced by the proportion of estimated total payments made to hospitals in Puerto Rico attributable to estimated outlier payments. We propose to set the same outlier offsets for the Puerto Rico prospective payment standardized amounts as we have for hospitals located outside Puerto Rico. These proposed outlier adjustment factors are as follows:

Urban	Rural
.94519	.97246

We are continuing to analyze the data and may revise these offsets in the final rule.

B. Calculation of National Standardized Amount for Puerto Rico

The national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national rural standardized amount and the national urban standardized amount (as set forth in Table 1a of this addendum). The national average standardized amount for Puerto Rico is set forth in Table 1c.

C. Adjustments for Area Wage Levels

Section 1886(d)(9)(B)(vi) of the Act requires that an adjustment be made to the labor-related portion of the Puerto Rico prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. (Table 1c sets forth the labor-related and nonlabor-related shares for both the Puerto Rico and the national standardized amounts that would be used to calculate the prospective payment rates for hospitals located in Puerto Rico.) The wage index is set forth in Tables 4a and 4b of this addendum.

D. DRG Weighting Factors

As discussed in section II of the preamble to this proposed rule, we have developed a classification system for all hospital discharges, sorting them into DRGs, and have developed weighting factors for each DRG that are intended to reflect the relative resource consumption associated with each DRG.

Table 5 of section VI of this addendum contains the weighting factors that we propose to use for discharges occurring in FY 1988. These factors have been recalibrated as explained in section II of the preamble.

E. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning on or After October 1, 1987 and Before October 1, 1988

Prospective Payment Rate for Puerto Rico hospitals=75 percent of the Puerto Rico Rate+25 percent of the National Rate.

1. Puerto Rico rate. The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the urban and rural designation of the hospital (see Table 1c, section VI of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index.

Step 3—Sum the amount from step 2 and the nonlabor portion of the standardized amount.

Step 4—Multiply the amount from step 3 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section VI of the addendum).

2. National rate. The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1c, section VI of the addendum) by the appropriate wage index.

Step 2—Sum the amount from step 1 and the nonlabor portion of the national average standardized amount.

Step 3—Multiply the amount from step 2 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section VI of the addendum).

IV. Budget Neutrality

The law requires that a number of adjustments be made to the average standardized amounts in order to achieve the payment levels anticipated by Congress in its revisions to section 1886 of the Act. In order to incorporate these adjustments, which are discussed in more detail below as well as in previous prospective payment rules, we used an iterative simulation process.

Using the most current data available (that is, bills for FY 1986 discharges from hospitals currently subject to the prospective payment system received in HCFA through February 1987 (approximately 9.5 million discharges)), we ran a baseline simulation using the PRICER program to price each case. Estimated payments were calculated using FY 1988 standardized amounts computed on the same basis as those published in the September 3, 1986 final rule (51 FR 31530), except that these rates were—

- Updated by 1.15 percent for FY 1987 (rather than by .5 percent as announced in the September 3, 1986 final rule) and further updated by 2.7 percent for FY 1988 as prescribed by section 1886(b)(3)(B)(i)(II) of the Act;
- Adjusted to reflect the restandardization of the wage index resulting from revising the methodology for computing the national average hourly wage; and
- Adjusted to take into account the additional payments to rural referral centers as required by section 1886(d)(5)(C)(i) of the Act.

The September 3, 1986 rates already included adjustments required by various provisions of Pub. L. 99–272, such as restandardization for indirect medical education payments, standardization for payments to hospitals serving a disproportionate share of low-income patients, and the adjustment for the indirect medical education payment equality factor (see 51 FR 31498–31529).

From this simulation, we calculated the ratio of total outlier payments to total payments (including outliers). We computed separate outlier payment ratios for hospitals in urban areas and hospitals in rural areas.

In addition, we calculated the total operating payments under the prospective payment system that we estimate would have occurred in FY 1988 using standardized amounts that were hospital-weighted and reduced uniformly for outliers by five percent. This amount served as the aggregate prospective payment target that had to be maintained after the urban and rural standardized amounts were discharge-weighted and differentially adjusted for urban and rural outlier ratios, respectively.

The next step was to discharge-weight the standardized amounts and to remove the effect of the five percent outlier adjustment from the FY 1988 standardized amounts and replace it with the outlier ratios for urban hospitals and rural hospitals as computed in the price simulation. However, these outlier ratios do not reflect our estimate of outlier payment ratios in FY 1988 because they are based on standardized payment amounts uniformly reduced by five percent. Therefore, further simulations were required to refine the outlier payment ratios used in computing the standardized amounts and to ensure that the total payment constraint was met.

We then used these revised rates to rerun the price simulation to refine the outlier payment ratios used to offset the standardized amounts in order to determine if aggregate payments based on these discharge weighted, differentially adjusted rates equal the target payment amount computed in the baseline price simulation.

The entire simulation process was repeated until the outlier ratios computed in the simulation and used to adjust the standardized rates resulted in total aggregate payments equal to the baseline target amount that represents our estimate of total prospective payment system payments for FY 1988 that would have been incurred had these provisions not been implemented.

The outlier adjustment and budget neutrality factors are as follows:

OUTLIER

Urban	Rural
.94519	.97246

BUDGET NEUTRALITY FACTOR

.97766

Section 1886(e)(1)(C) of the Act requires that the incorporation of hospitals in Puerto Rico into the prospective payment system in FY 1988 be accomplished in a budget-neutral fashion; that is, the aggregate payment to prospective payment hospitals including those located in Puerto Rico must be neither greater nor less than the payment amount that would have been made to those hospitals had section 9304 of Pub. L. 99–509, which added Puerto Rico hospitals to the prospective payment system, not been enacted. Accordingly, we analyzed what the total payment for FY 1988 would be if all prospective payment hospitals, including hospitals located in Puerto Rico, are paid under the prospective payment system and what the total payment for FY 1988 would be for these hospitals if the hospitals located in Puerto Rico are paid as if they are still subject to the rate-of-increase limits and all other hospitals receive their payment under the prospective payment system. The difference in payment amounts is considerably less than 0.1 percent, and, consequently, the budget neutrality adjustment for incorporating hospitals in Puerto Rico into the prospective payment system is negligible. Therefore, we believe that it is unnecessary to adjust the average standardized amounts to achieve budget neutrality. If later evidence indicates the need for such an adjustment, we will make it in the final rule.

V. Proposed Target Rate Percentages for Hospitals and Hospital Units Excluded From the Prospective Payment System

A. Background

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 413.40 of the regulations. Under these limits, an annual target amount (stated as inpatient operating cost per discharge) is set for each hospital, based on the hospital's own cost experience This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

A hospital that has inpatient operating costs per discharge in excess of its target amount would be paid no more than that amount. However, a hospital that has inpatient operating costs less than its target amount would be paid its costs plus the lower of (1) 50 percent of the difference between the inpatient operating cost per discharge and the target amount, or (2) five percent of the target amount.

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage for the

12-month period, prorated based on calendar year target rate percentages. For cost reporting periods beginning in FY 1983 and FY 1984, the applicable target rate percentage was the estimated hospital market basket increase factor plus one percentage point. For cost reporting periods beginning in FY 1985, the applicable target rate percentage was the estimated hospital market basket increase factor plus one-quarter of one percentage point. Under section 9101(e)(3) of Pub. L. 99-272, the applicable target rate percentage increase for cost reporting periods beginning on or after October 1, 1985 through September 30, 1986 is 5/24 of one percent. Section 9101 of Pub. L. 99-272 provides that for purposes of updating the target rate for FY 1987, the FY 1986 increase will be deemed to have been one-half of one percent. For cost reporting periods beginning in FY 1987, section 9302(a) of Pub. L. 99-509 provides that the applicable percentage increase is 1.15 percent.

B. Proposed Target Amounts for Cost Reporting Periods Beginning in FY 1988

For cost reporting periods beginning in FY 1988, under section 1886(b)(3)(B)(i)(II) of the Act, as amended by section 9302(a) of Pub. L. 99-509, the applicable percentage increase is the market basket percentage increase minus 2.0 percentage points. Therefore, we are proposing to increase each hospital's previous year's target amount by 2.7 percent. Thus, the same percentage increase applies to the target rate amounts for hospitals and units excluded from the prospective payment system as applies to the prospective payment rates for hospitals subject to that system.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this addendum. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1a, 1b, 1c, 3c, 4a, 4b, and 5 are presented below. The tables are as follows:

Table 1a—National Adjusted Standardized Amounts, Labor/Nonlabor

Table 1b—Regional Adjusted Standardized Amounts, Labor/Nonlabor

Table 1c—Adjusted Standardized Amounts for Puerto Rico, Labor/Nonlabor

Table 2—Hospital Market Basket (September 3, 1986 final rule—51 FR 31530)

Table 3a—Hospital Case Mix (September 1, 1983 final rule—48 FR 39871)

Table 3b—Average Case Mix Indexes by Hospital Classification Group (September 1, 1983 final rule—48 FR 39871)

Table 3c—Hospital Case-Mix Indexes for Discharges Occurring in FY 1986

Table 4a—Wage Index for Urban Areas

Table 4b—Wage Index for Rural Areas

Table 5 Diagnosis-Related Groups

TABLE 1a.—NATIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR

Urban		Rural	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2346.45	831.43	2124.82	588.42

TABLE 1b.—REGIONAL ADJUSTED STANDARDIZED AMOUNTS, LABOR/NONLABOR [1]

	Urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
1. New England (CT, ME, MA, NH, RI, VT)	2452.04	863.31	2352.03	697.42
2. Middle Atlantic (PA, NJ, NY)	2223.34	827.59	2255.52	658.00
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2357.44	756.87	2157.20	572.67
4. East North Central (IL, IN, MI, OH, WI)	2487.01	895.72	2182.45	635.29
5. East South Central (AL, KY, MS, TN)	2264.10	687.41	2137.93	533.88
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2356.01	815.36	2074.27	569.82
7. West South Central (AR, LA, OK, TX)	2365.95	756.39	1992.34	524.58
8. Mountain (AZ, (CO, ID, MT, NV, NM, UT, WY)	2257.42	804.67	2024.44	606.96
9. Pacific (AK, CA, HI, OR, WA)	2207.70	923.35	1959.91	679.80

[1] Applicable only to Sole Community Hospitals.

TABLE 1c.—ADJUSTED STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Urban		Rural	
	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
Puerto Rico	2008.13	359.42	1665.76	318.11

	Labor-related	Nonlabor-related
National	2294.03	773.96

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TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
010001	01.1629	010058	01.1498	010119	01.0767	020026	01.3790	030067	01.0150
010004	00.9564	010059	00.9240	010120	00.9352	020027	01.0071	030068	01.0429
010005	01.0925	010060	00.9845	010121	01.0612	030001	01.1472	030069	01.1696
010006	01.1548	010061	00.9902	010122	00.9278	030002	01.4703	030071	00.9263
010007	00.9384	010062	00.8943	010123	01.1135	030003	01.1663	030072	00.9215
010008	00.9955	010064	01.3575	010124	01.0628	030004	00.9091	030073	01.1235
010009	01.0183	010065	01.0501	010125	00.9339	030006	01.3250	030074	00.9524
010010	01.0209	010066	00.8777	010126	00.9938	030007	01.1236	030075	00.9029
010011	01.2014	010067	00.9490	010127	01.1224	030008	01.2586	030076	00.8765
010012	01.2079	010068	01.1230	010128	01.0183	030009	01.2165	030077	00.9010
010015	00.9943	010069	01.0924	010129	01.0571	030010	01.2951	030078	01.1102
010016	01.1628	010070	01.1768	010130	01.0743	030011	01.1768	030079	00.9048
010017	01.1083	010072	01.0766	010131	01.0860	030012	01.0661	030080	01.3377
010018	00.9677	010073	00.9994	010133	00.9240	030013	01.1171	030081	00.8976
010019	01.0652	010074	00.9515	010134	00.9404	030014	01.1553	030082	00.8180
010020	00.9805	010075	01.0882	010136	01.0365	030016	01.0938	030083	01.1440
010021	01.0522	010078	01.1601	010137	01.1940	030017	01.1717	030084	01.0479
010022	00.9896	010079	01.0393	010138	00.9439	030018	01.2036	030085	01.0856
010023	01.1506	010080	00.9650	010139	01.4145	030019	01.1205	030086	01.0785
010024	01.1501	010081	01.4036	010142	00.9149	030020	01.3153	030087	01.1237
010025	01.1080	010083	00.9964	010143	01.0669	030022	01.2459	030088	01.1763
010026	00.9549	010084	01.1534	010144	01.0749	030023	01.2306	030089	01.1339
010027	00.9625	010085	01.1154	010145	01.1220	030024	01.4273	030091	00.8996
010028	00.9599	010086	00.9273	010146	01.0244	030025	01.1460	040001	01.0430
010029	01.1789	010087	01.2326	010148	00.9556	030027	00.9781	040002	01.0546
010030	00.8994	010089	01.0403	010149	01.1247	030030	01.3058	040003	00.9738
010031	01.1113	010090	01.2198	010150	00.9925	030033	01.0922	040004	01.2076
010032	00.9169	010091	01.0056	010152	01.1492	030034	01.1155	040005	01.0446
010033	01.7149	010092	01.2681	010153	00.9220	030035	01.1347	040006	01.0248
010034	00.9814	010094	00.9939	020001	01.2487	030036	01.1203	040007	01.3018
010035	01.0518	010095	01.0972	020002	01.1626	030037	01.6218	040008	01.0056
010036	01.0402	010096	00.9699	020004	01.0901	030038	01.3347	040009	01.0222
010038	00.9747	010097	00.9455	020005	01.0331	030040	01.0779	040010	01.1227
010039	01.3642	010098	01.0276	020006	01.1153	030041	00.9088	040011	00.8851
010040	01.1291	010099	01.0598	020007	01.0592	030043	01.0562	040013	01.0197
010041	00.8842	010100	01.1690	020008	01.0672	030044	00.9892	040014	01.1413
010043	00.9607	010101	01.0204	020009	00.9293	030046	01.0499	040015	01.0237
010044	00.8953	010102	00.9944	020010	00.9748	030047	00.9272	040016	01.2735
010045	00.9960	010103	01.3167	020011	00.9196	030049	01.0130	040017	01.1626
010046	01.1463	010104	01.3705	020012	01.1651	030051	01.0542	040018	01.1304
010047	00.9791	010108	01.0706	020013	00.8967	030054	00.9597	040019	01.0432
010049	01.0111	010109	01.0694	020014	01.0076	030055	01.0531	040020	01.3060
010050	00.9907	010110	00.9194	020016	00.9629	030057	01.2021	040021	01.1431
010051	00.9649	010111	00.9650	020017	01.0828	030059	01.0894	040022	01.2260
010052	00.9231	010112	01.0370	020018	00.9912	030060	01.1416	040024	00.9715
010053	01.0377	010113	01.3420	020019	00.9921	030061	01.2863	040025	00.9604
010054	01.1031	010114	01.1419	020020	00.9055	030062	01.1035	040026	01.2210
010055	01.2376	010115	00.9444	020021	00.9063	030063	01.1209	040027	01.1215
010056	01.1469	010117	01.0089	020024	01.0277	030064	01.4162	040028	01.0533
010057	01.0115	010118	01.1153	020025	01.0735	030065	01.4338	040029	01.0103

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040030	00.9665	040100	01.1363	050046	01.1047	050104	01.2606	050166	01.1640
040031	00.9877	040105	00.9863	050047	01.5054	050107	01.1789	050167	01.1989
040032	00.9755	040106	01.0250	050049	01.1465	050108	01.2835	050168	01.4285
040033	00.9154	040107	00.9844	050051	00.9935	050109	01.8835	050169	01.3070
040035	00.9210	040108	00.9093	050052	01.1202	050110	01.0841	050170	01.2425
040036	01.1075	040109	01.1587	050053	01.1969	050111	01.1764	050172	01.1779
040037	01.0582	040114	01.5476	050054	01.1625	050112	01.3307	050173	01.1288
040039	01.0054	040115	00.9681	050055	01.1395	050113	01.1810	050174	01.4425
040040	01.0255	040116	01.1468	050056	01.1344	050114	01.3003	050175	01.1491
040041	01.1047	040118	01.0632	050057	01.2338	050115	01.2486	050177	01.2226
040042	01.2070	040119	01.1273	050058	01.2577	050116	01.3169	050179	01.1218
040043	00.9828	040122	01.0134	050060	01.2749	050117	01.1440	050180	01.2668
040044	00.9529	040123	00.9563	050061	01.1963	050118	01.1136	050181	01.1427
040045	00.9208	040124	01.0242	050063	01.2362	050119	00.8722	050182	01.0993
040047	01.0409	040126	00.9312	050065	01.3629	050121	01.0917	050183	01.1375
040048	01.1435	040127	00.8518	050066	01.1889	050122	01.2374	050186	01.1749
040050	01.0146	040128	00.9190	050067	01.1212	050124	01.2242	050187	01.0318
040051	00.9767	050002	01.1556	050068	01.0719	050125	01.1755	050188	01.2115
040053	00.9434	050004	01.1844	050069	01.4031	050126	01.2232	050189	00.9930
040054	00.9713	050006	01.2347	050070	01.1684	050127	01.1939	050190	01.1029
040055	01.2406	050007	01.3936	050071	01.2040	050128	01.2676	050191	01.2734
040058	00.9446	050008	01.2454	050072	01.2004	050129	01.4733	050192	01.0568
040060	00.9599	050009	01.2963	050073	01.1190	050131	01.2457	050193	01.2169
040062	01.1980	050011	01.1255	050074	00.9377	050132	01.2219	050194	01.1823
040063	01.2821	050013	01.8052	050075	01.1986	050133	01.1398	050195	01.1766
040064	00.9708	050014	01.1225	050076	01.4455	050134	01.1257	050196	01.2200
040066	00.9456	050015	01.2797	050077	01.4119	050135	01.3649	050197	01.6746
040067	00.9778	050016	01.0779	050078	01.2153	050136	01.1929	050199	01.1804
040068	01.0563	050017	01.5961	050079	01.2002	050137	01.1758	050200	01.1367
040069	01.0302	050018	01.0855	050080	01.1547	050138	01.4182	050201	01.1348
040070	00.9412	050019	00.9525	050081	01.3238	050139	01.2003	050202	01.1767
040071	01.1581	050021	01.1744	050082	01.2333	050140	01.1539	050204	01.2748
040072	01.0185	050022	01.2527	050084	01.3575	050141	01.2342	050205	01.1554
040074	01.0582	050024	01.1169	050086	01.2839	050143	01.2147	050207	01.1678
040075	01.0642	050025	01.4352	050087	01.2431	050144	01.3463	050208	01.1996
040076	00.9738	050026	01.2413	050088	01.1426	050145	01.2317	050210	01.0166
040077	00.9498	050028	01.2528	050089	01.1677	050147	00.9961	050211	01.1865
040078	01.1989	050029	01.2059	050090	01.1677	050148	01.0996	050212	01.0557
040080	01.0498	050030	01.1432	050091	01.1534	050149	01.1614	050213	01.1891
040081	00.9135	050032	01.0538	050092	01.1055	050150	01.2244	050214	01.2761
040082	01.0840	050033	01.3017	050093	01.4329	050151	01.2252	050215	01.2913
040084	01.0353	050034	01.1697	050095	01.0580	050152	01.2260	050217	01.1900
040085	00.9499	050036	01.2304	050096	01.1552	050153	01.3995	050219	01.2369
040087	00.9501	050038	01.2154	050097	01.2537	050154	01.0952	050220	01.0688
040088	01.1676	050039	01.4498	050098	01.0685	050155	01.0930	050221	01.1740
040090	00.9253	050040	01.0435	050099	01.2710	050156	01.1851	050222	01.1126
040091	00.9667	050041	01.1331	050100	01.7448	050158	01.4620	050224	01.2059
040093	00.9555	050042	01.1375	050101	01.2379	050159	01.1453	050225	01.1587
040095	00.9905	050043	01.5250	050102	01.2388	050161	01.1919	050226	01.4574
040098	01.1127	050045	01.0936	050103	01.3415	050164	01.1921	050228	01.2226

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050229	01.1962	050298	01.0844	050372	01.1081	050442	01.1355	050527	01.1436
050230	01.2006	050299	01.3011	050373	01.0915	050443	00.9609	050528	01.0783
050231	01.1976	050300	01.1944	050376	01.2469	050444	01.1269	050530	01.2141
050232	01.4974	050301	01.1240	050377	01.1650	050446	00.9691	050531	01.1949
050233	01.1276	050302	01.2344	050378	01.0539	050447	01.2052	050534	01.2227
050234	01.2111	050303	01.4535	050379	01.0007	050448	00.9936	050535	01.1468
050235	01.2677	050305	01.2365	050380	01.5134	050449	01.1378	050537	01.1912
050236	01.2113	050307	01.2473	050381	00.9618	050450	01.0166	050539	01.1565
050238	01.1646	050308	01.4099	050382	01.2304	050451	01.0132	050541	01.3768
050239	01.2584	050309	01.1655	050383	01.2344	050454	01.6468	050542	01.0020
050240	01.2339	050310	01.1056	050385	01.2158	050455	01.4033	050543	01.1661
050241	01.1794	050312	01.2558	050387	01.0085	050456	01.2856	050544	01.1307
050242	01.2729	050313	01.1258	050388	00.9803	050457	01.3948	050545	00.8859
050243	01.2031	050315	01.1864	050390	01.1906	050458	00.8801	050546	00.9026
050245	01.3609	050317	01.1729	050391	01.1920	050459	01.2324	050547	00.9922
050248	01.1838	050318	00.9979	050392	00.8948	050464	01.6316	050548	00.7652
050251	01.0504	050319	01.2498	050393	01.2581	050467	01.2016	050549	01.4986
050253	01.2676	050320	01.1022	050394	01.3811	050468	01.1750	050550	01.2307
050254	01.1651	050324	01.5258	050395	01.1089	050469	00.9772	050551	01.2380
050256	01.4397	050325	01.1581	050396	01.4195	050470	01.1150	050552	01.2133
050257	01.2226	050326	01.2343	050397	01.0032	050471	01.2826	050557	01.1933
050258	01.2285	050327	01.4748	050401	01.1846	050473	01.1419	050559	01.1714
050260	00.8936	050328	01.1074	050404	01.0755	050476	01.1100	050560	01.1171
050261	01.1192	050329	01.1328	050406	01.0101	050477	01.0693	050561	01.0953
050262	01.4299	050331	01.1658	050407	01.1399	050478	01.1057	050562	01.1009
050263	01.2012	050333	00.9979	050410	00.9706	050481	01.1943	050564	01.1293
050264	01.2307	050334	01.2029	050411	01.1785	050482	01.0824	050565	01.1070
050267	01.4336	050335	01.0959	050413	01.2382	050483	01.1414	050566	01.0357
050268	01.2329	050336	01.1873	050414	01.1137	050485	01.3621	050567	01.2386
050269	01.1509	050337	01.0508	050415	00.8541	050486	01.2711	050568	01.1519
050270	01.1642	050342	01.2408	050417	01.1397	050487	01.1637	050569	01.1463
050272	01.2284	050343	01.2307	050418	01.0671	050488	01.2015	050570	01.4198
050273	01.0332	050345	01.2258	050419	01.1732	050489	01.0844	050571	01.2274
050274	00.8796	050348	01.2998	050420	01.1905	050491	01.1738	050573	01.3954
050276	01.0610	050349	00.9693	050421	01.1977	050492	01.1063	050575	01.1011
050277	01.1608	050350	01.2428	050423	01.0479	050494	01.0777	050576	01.1433
050278	01.2184	050351	01.3541	050424	01.2995	050496	01.5936	050577	01.2522
050279	01.1340	050352	01.1427	050425	01.1873	050497	00.8959	050578	01.0972
050280	01.2143	050353	01.4734	050426	01.1376	050498	01.1641	050579	01.1515
050281	01.2909	050355	01.0397	050427	00.9183	050502	01.7499	050580	01.1311
050282	01.1919	050357	01.4374	050430	00.9177	050503	01.2733	050581	01.2100
050283	01.2157	050359	01.1105	050431	01.1012	050506	01.2156	050583	01.5605
050286	01.0736	050360	01.1987	050432	01.2982	050510	01.1284	050584	01.0881
050289	01.6109	050361	00.9621	050433	01.0008	050512	01.1537	050585	01.2516
050290	01.3188	050362	01.1351	050434	01.1162	050515	01.2305	050586	01.1096
050291	01.1536	050363	01.1175	050435	01.1655	050516	01.2326	050587	01.1699
050292	01.1792	050366	01.1348	050436	01.0174	050517	01.1242	050588	01.1991
050293	00.8584	050367	01.1671	050438	01.3866	050522	01.1583	050589	01.1878
050295	01.1764	050369	01.1398	050440	01.1196	050523	01.1024	050590	01.2043
050296	01.2160	050371	01.0668	050441	01.5239	050526	01.1513	050591	01.1673

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050592	01.1817	060003	01.1535	060057	01.1266	070022	01.5344	100019	01.1739
050593	01.1733	060004	01.0636	060058	00.9240	070023	01.1702	100020	01.1790
050594	02.1321	060005	01.3347	060060	01.1057	070024	01.1605	100021	01.1320
050597	01.1108	060006	01.2073	060062	01.0301	070025	01.4433	100022	01.3400
050598	01.1473	060007	01.1068	060063	01.1794	070026	01.1793	100023	01.1287
050599	01.3022	060008	01.1321	060064	01.2694	070027	01.2394	100024	01.1623
050601	01.1597	060009	01.2215	060065	01.1242	070028	01.3305	100025	01.3566
050603	01.2774	060010	01.3908	060066	01.0467	070029	01.1550	100026	01.2643
050604	01.2437	060011	01.1685	060067	01.0239	070030	01.1360	100027	01.0293
050605	00.9395	060012	01.3307	060068	01.2356	070031	01.2598	100028	01.1087
050607	01.1366	060013	01.2049	060070	01.1796	070033	01.2069	100029	01.1370
050608	01.0786	060014	01.3987	060071	01.2343	070034	01.2266	100030	01.0274
050609	01.2244	060015	01.3136	060072	01.0030	070035	01.2498	100032	01.2180
050613	00.9405	060016	01.1993	060073	00.9810	070036	01.2675	100033	01.1455
050615	01.1864	060017	01.1985	060074	00.9723	070038	01.0805	100034	01.2920
050616	01.1169	060018	01.0957	060075	01.2010	080001	01.1955	100035	01.1810
050618	01.0562	060019	01.2352	060076	01.2394	080002	01.1292	100036	01.1341
050619	01.2286	060020	01.2499	060077	00.9512	080003	01.1949	100038	01.3080
050622	01.0835	060022	01.4342	060083	01.0770	080004	01.2227	100039	01.2516
050623	01.1719	060023	01.2973	060085	00.9799	080005	01.0451	100040	01.3601
050624	01.1543	060024	01.4189	060087	01.1230	080006	01.0242	100042	01.1154
050625	01.3077	060025	01.0526	060088	00.9743	080007	01.1688	100043	01.2026
050630	01.0649	060026	01.2582	060090	01.0558	090001	01.2698	100044	01.1628
050633	01.1527	060027	01.2109	060092	00.6627	090002	01.0547	100045	01.1329
050635	01.2017	060028	01.3237	060093	00.8432	090003	01.2724	100046	01.1267
050636	01.2115	060029	00.9915	060096	00.9601	090004	01.4370	100047	01.1223
050637	01.1236	060030	01.1900	060097	01.0245	090005	01.1921	100048	00.9769
050638	00.9272	060031	01.3484	060098	01.1360	090006	01.2166	100049	01.0866
050641	01.0615	060032	01.2967	060099	00.8054	090007	01.1373	100050	01.0129
050643	01.0203	060033	01.1929	070001	01.5399	090008	01.1616	100051	01.0457
050644	01.1222	060034	01.2301	070002	01.4938	090009	01.1193	100052	01.2215
050646	01.0626	060035	01.2011	070003	01.1952	090010	01.0946	100053	01.1070
050649	01.0125	060036	01.1506	070004	01.1615	090011	01.5950	100054	01.1382
050650	01.1427	060037	00.9895	070005	01.2884	100001	01.2325	100055	01.1347
050651	01.1366	060038	01.2333	070006	01.1798	100002	01.2374	100056	01.1049
050657	01.0923	060039	01.1305	070007	01.2011	100004	00.9659	100057	01.1185
050661	00.8359	060041	01.1639	070008	01.1077	100005	01.0393	100059	01.2423
050663	01.1128	060042	01.0244	070009	01.2057	100006	01.3227	100060	01.4601
050665	00.5721	060043	01.0384	070010	01.3900	100007	01.6188	100061	01.2003
050666	00.9577	060044	01.1668	070011	01.1724	100008	01.2334	100062	01.1669
050668	01.1796	060045	01.0480	070012	01.1701	100009	01.2719	100063	01.1320
050669	00.7385	060046	01.1076	070013	01.2102	100010	01.1752	100063	01.1320
050672	00.6630	060047	00.9828	070014	01.1205	100011	00.9382	100065	01.0568
050673	00.9498	060049	01.1752	070015	01.1594	100012	01.2398	100067	01.1838
050674	01.1218	060050	01.1671	070016	01.2523	100013	00.9802	100068	01.1081
050675	01.1953	060051	01.2717	070017	01.2469	100014	01.1540	100069	01.1157
050676	00.8637	060052	01.0281	070018	01.1969	100015	01.0927	100070	01.2399
050677	01.1239	060053	00.9682	070019	01.1544	100016	01.0025	100071	01.1580
050678	00.9816	060054	01.2028	070020	01.2411	100017	01.2443	100072	01.1304
060001	01.3430	060056	00.9590	070021	01.1981	100018	01.1773	100073	01.3671

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
100074	01.0985	100137	01.1145	100203	01.1768	100262	01.1542	110046	01.0742
100075	01.3984	100138	00.9579	100204	01.3368	100263	01.1326	110047	00.9419
100076	01.1430	100139	01.0519	100206	01.1670	100264	01.1887	110048	01.0172
100077	01.1599	100140	01.0745	100207	01.1530	100265	01.1251	110049	00.9376
100078	01.0175	100142	01.0415	100208	01.1398	100266	01.1450	110050	01.0203
100079	01.1295	100143	01.0116	100209	01.2410	100267	01.1741	110051	00.9368
100080	01.1743	100144	01.0272	100210	01.3484	100268	01.0763	110052	00.9362
100081	01.0252	100145	01.1017	100211	01.1510	100269	01.1833	110054	01.1834
100082	01.1966	100146	00.9907	100212	01.1231	100270	00.8930	110055	00.9209
100083	01.1134	100147	01.0363	100213	01.2107	110001	01.0989	110056	00.9341
100084	01.1029	100149	01.1198	100214	01.1176	110002	01.1331	110059	01.0402
100085	01.0652	100150	01.1611	100217	01.0663	110003	01.1255	110061	00.9199
100086	01.1639	100151	01.5043	100218	01.1325	110004	01.0874	110062	00.9464
100087	01.4430	100152	01.1011	100218	01.1325	110005	01.0692	110063	00.9947
100088	01.2815	100153	00.8980	100219	01.1880	110006	01.1347	110064	01.1959
100089	01.1213	100154	01.2913	100220	01.3669	110007	01.3144	110065	00.9493
100090	01.1151	100156	01.0331	100221	01.5833	110008	01.0189	110066	01.2018
100092	01.1069	100157	01.2971	100222	01.0850	110009	01.0578	110069	01.0692
100093	01.2174	100159	01.0096	100223	01.2029	110010	01.8216	110070	01.0068
100098	00.9580	100160	00.9858	100224	01.1001	110011	01.0765	110071	00.9907
100099	01.0984	100161	01.1864	100225	01.1151	110013	00.9768	110072	00.9658
100100	01.0960	100162	01.1189	100226	01.1741	110014	00.9290	110073	01.0298
100102	01.0200	100164	00.9873	100227	00.9787	110015	01.0118	110074	01.1735
100103	00.9449	100165	00.9634	100228	01.1123	110016	01.1833	110075	01.0552
100105	01.1609	100166	01.1395	100229	01.1411	110017	00.9427	110076	01.2397
100106	01.0637	100167	01.1765	100230	01.0672	110018	01.0954	110077	00.9217
100107	01.1008	100168	01.1558	100231	01.4579	110020	01.0365	110078	01.3848
100108	01.0055	100169	01.4381	100232	01.0297	110023	01.0658	110079	01.0970
100109	01.0992	100170	01.1243	100234	01.1592	110024	01.1813	110080	01.1120
100110	01.1583	100172	01.0987	100235	01.1466	110025	01.1630	110081	01.0087
100112	00.9408	100173	01.1399	100236	01.1617	110026	01.0232	110082	01.6990
100113	01.4273	100174	01.2631	100237	01.6381	110027	00.9777	110083	01.1854
100114	01.1641	100175	01.0129	100238	01.1422	110028	01.3697	110085	01.0939
100115	01.1081	100176	01.4812	100239	01.2397	110029	01.1088	110086	01.1081
100117	01.1007	100177	01.1778	100240	00.7261	110030	01.1150	110087	01.1174
100118	01.0650	100179	01.3515	100241	00.8822	110031	01.0856	110088	00.9245
100120	01.0338	100180	01.2529	100242	01.1458	110032	01.0947	110089	01.1159
100121	01.0117	100181	01.0751	100243	01.1706	110033	01.0691	110091	01.1794
100122	01.1298	100183	01.1023	100244	01.1370	110034	01.2209	110092	01.0109
100124	01.1017	100185	01.0567	100245	01.1845	110035	01.1354	110093	01.0168
100125	01.0984	100186	01.2249	100248	01.3996	110036	01.4717	110094	00.8953
100126	01.2110	100187	01.1228	100249	01.0643	110037	00.9912	110095	01.1499
100127	01.2670	100189	01.1298	100252	01.1092	110038	01.1556	110096	00.9856
100128	01.9726	100191	01.1631	100253	01.1814	110039	01.0942	110097	00.9304
100129	01.1367	100193	00.8399	100254	01.2311	110040	00.9920	110098	00.9112
100130	01.0976	100194	01.0782	100255	01.1262	110041	01.0698	110099	00.9627
100131	01.1477	100195	01.1884	100256	01.1435	110042	00.9861	110100	01.0443
100132	01.1949	100196	01.1776	100258	01.1374	110043	01.2217	110101	00.9451
100134	00.9185	100199	01.1973	100259	01.1128	110044	01.1061	110103	00.9504
100135	01.3929	100200	01.1372	100260	01.1353	110045	01.0015	110104	01.0560

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
110105	01.1204	110169	00.6667	130002	01.2322	140005	00.8956	140065	01.1922
110107	01.3912	110170	00.8401	130003	01.1588	140007	01.1745	140066	01.0535
110108	00.9212	110171	01.2313	130005	01.2166	140008	01.2356	140067	01.3382
110109	00.9657	110172	01.1462	130006	01.5356	140009	01.0064	140068	01.0704
110111	00.9452	110174	00.9024	130007	01.2979	140010	01.2667	140069	01.0940
110112	00.9306	110175	01.0737	130008	00.9109	140011	01.0708	140070	01.1523
110113	00.9920	110176	01.1106	130009	00.9708	140012	01.1707	140072	01.1125
110114	01.0588	110177	01.1465	130010	00.9577	140013	01.1594	140074	01.0100
110115	01.3278	110178	00.9725	130011	01.1566	140014	00.9994	140075	01.2480
110117	00.9337	110179	01.1344	130012	00.9404	140015	01.1078	140077	00.9860
110118	00.9475	110181	01.0388	130013	01.1264	140016	01.0404	140079	01.0945
110120	00.9359	110183	01.1360	130014	01.1773	140017	01.1298	140080	01.6006
110121	00.9431	110184	01.0485	130015	01.0503	140018	01.2521	140081	01.0786
110122	01.1697	110185	00.9399	130016	00.9600	140019	00.9567	140082	01.1421
110123	01.0075	110186	01.0403	130017	01.0028	140023	01.0389	140083	01.0823
110124	00.9964	110187	00.9880	130018	01.2017	140024	00.9770	140084	01.1638
110125	01.0567	110188	01.1148	130019	01.0311	140025	01.0830	140085	01.1988
110127	01.0043	110189	00.9671	130021	00.9177	140026	01.1052	140086	01.0368
110128	01.0706	110190	00.9952	130022	01.1061	140027	01.0683	140087	01.1461
110129	01.3127	110191	01.1166	130024	01.1442	140029	01.1933	140088	01.3757
110130	00.9094	110192	01.2037	130025	01.0424	140030	01.3057	140089	01.0713
110131	00.8920	110193	01.0635	130026	01.1210	140031	01.0502	140090	01.2002
110132	00.9762	110194	01.0162	130027	00.8951	140032	01.0878	140091	01.2988
110133	00.9741	110195	00.9670	130028	01.1283	140033	01.1053	140093	01.1004
110134	00.8987	110196	01.3139	130029	01.1226	140034	01.0415	140094	01.0707
110135	00.9636	110198	01.2112	130030	00.9211	140035	01.0906	140095	01.0928
110136	00.9878	110200	01.4657	130031	00.9351	140036	01.0269	140097	01.1510
110140	00.8852	110201	01.1746	130032	00.9721	140037	00.9925	140098	01.1694
110141	00.8992	110202	00.9934	130034	00.9242	140038	01.1061	140099	01.1716
110142	01.0186	120001	01.3972	130035	01.0466	140039	01.0327	140100	01.0757
110143	01.1494	120002	01.0960	130036	01.1153	140040	01.0929	140101	01.1275
110144	01.1423	120003	01.0962	130037	01.0290	140041	00.9887	140102	00.9643
110146	00.8681	120004	01.1513	130038	00.8811	140042	01.0249	140102	00.9643
110149	00.9649	120005	01.1698	130039	01.1315	140043	01.0906	140103	01.0827
110150	01.0608	120006	01.0776	130040	00.9542	140045	01.0522	140104	01.0810
110151	00.9672	120007	01.3126	130041	00.8715	140046	01.0737	140105	01.2031
110152	00.9655	120008	00.9853	130043	00.9695	140047	01.0873	140107	00.9456
110153	00.9492	120009	00.9792	130044	00.9440	140048	01.0865	140108	01.1269
110154	00.8910	120010	01.4132	130045	01.0111	140049	01.2325	140109	01.0000
110155	00.9933	120011	01.2806	130048	00.9091	140051	01.1638	140110	01.0700
110156	00.9132	120012	01.0118	130049	01.1773	140052	01.1393	140111	00.9530
110157	01.1167	120014	01.1169	130050	01.3711	140053	01.4188	140112	01.0655
110158	01.0199	120015	00.9955	130051	01.0516	140054	01.2401	140113	01.3296
110161	01.2372	120016	01.0414	130053	00.9772	140055	00.9662	140114	01.0938
110162	01.0167	120018	00.9473	130054	00.8079	140058	01.0384	140115	01.0245
110163	01.1830	120019	01.0564	130055	00.8957	140059	00.9998	140116	01.2084
110164	01.2193	120021	01.0287	140001	01.0901	140061	01.0287	140117	01.1647
110165	01.1446	120022	01.3932	140002	01.1668	140062	01.1235	140118	01.3334
110166	01.2370	120024	00.8892	140003	00.9390	140063	01.1463	140119	01.4380
110168	01.1665	130001	01.0392	140004	01.0388	140064	01.1200	140120	01.0679

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140121	01.0543	140173	01.0804	140234	01.1104	150013	01.0454	150069	01.1264
140122	01.2109	140174	01.1957	140235	00.9767	150014	01.1934	150070	01.1160
140123	01.1268	140176	01.1011	140236	01.0229	150015	01.1344	150071	01.1627
140124	01.0129	140177	01.0505	140239	01.3392	150017	01.4657	150072	01.1592
140125	01.0885	140178	00.9983	140240	01.1806	150018	01.1634	150073	01.0642
140126	01.3279	140179	01.1873	140241	00.9067	150019	01.1396	150074	01.2819
140127	01.1630	140180	01.2678	140242	01.2033	150020	01.0728	150075	01.1743
140128	01.0506	140181	01.0797	140243	01.1029	150021	01.3963	150076	01.0341
140129	01.0304	140182	01.2002	140245	01.0379	150022	01.0867	150077	01.0909
140130	01.1131	140184	01.0619	140246	01.0544	150023	01.1883	150078	01.0322
140131	01.1017	140185	01.1858	140247	01.0001	150024	01.1177	150079	01.1085
140132	01.3092	140186	01.0750	140248	01.1096	150025	01.2832	150081	01.0413
140133	01.1747	140187	01.2031	140249	00.8426	150026	01.1697	150082	01.2836
140134	01.1311	140188	00.9472	140250	01.1334	150027	01.0904	150083	01.0537
140135	01.0942	140189	01.1145	140251	01.1435	150029	01.1282	150084	01.6149
140136	00.9860	140190	01.0080	140252	01.1865	150030	01.1327	150085	00.9377
140137	01.0624	140191	01.1277	140253	01.1233	150031	00.9841	150086	01.0891
140138	01.0012	140192	01.0807	140258	01.2229	150032	01.6231	150088	01.0913
140139	00.9946	140193	00.9873	140261	01.0613	150033	01.2926	150089	01.2128
140140	01.0732	140193	00.9873	140271	00.9581	150034	01.1133	150090	01.1762
140141	00.9484	140197	01.2023	140273	01.0244	150035	01.1344	150091	01.0874
140142	01.0909	140199	01.0510	140275	01.1050	150036	01.0250	150092	01.0181
140143	01.1018	140200	01.2095	140276	01.7979	150037	01.1472	150094	01.0717
140144	01.0185	140202	01.1345	140280	01.1398	150038	01.1563	150095	01.0597
140145	01.0546	140203	01.0225	140281	01.3382	150039	01.0459	150096	01.0216
140146	00.9366	140204	01.2038	140285	01.0712	150042	01.1452	150097	01.0586
140147	01.0292	140205	01.0364	140286	01.1568	150043	01.1136	150098	01.0516
140148	01.3153	140206	01.1137	140288	01.2112	150044	01.1352	150099	01.0679
140150	01.2334	140207	01.1230	140289	01.1939	150045	01.0880	150100	01.2992
140151	01.0327	140208	01.2586	140290	01.1251	150046	01.2262	150101	01.0431
140152	01.0160	140209	01.2485	140291	01.1336	150047	01.3192	150102	01.0304
140153	01.0668	140210	01.0477	140292	01.1230	150048	01.1519	150103	01.0122
140154	01.1371	140211	01.0841	140293	01.0035	150049	01.0493	150104	01.0618
140155	01.0344	140212	01.0112	140294	01.0048	150050	01.1309	150105	01.1024
140156	01.1906	140213	01.1069	140295	01.0907	150051	01.1577	150106	01.0302
140157	01.0303	140215	01.0834	140296	00.8477	150052	00.9843	150109	01.1929
140158	01.1820	140216	00.9163	140297	01.1928	150053	01.0169	150110	00.9121
140159	01.0986	140217	01.1577	140298	01.1799	150054	00.9962	150111	01.0192
140160	01.1818	140218	01.0342	150001	01.1269	150056	01.3845	150112	01.1534
140161	01.0206	140219	01.1100	150002	01.2104	150057	00.9617	150113	01.1119
140162	01.1460	140220	01.0515	150003	01.3437	150058	01.3176	150114	01.0209
140163	00.9507	140223	01.2899	150004	01.1772	150059	01.0833	150115	01.1640
140164	01.1214	140224	01.1911	150005	01.1246	150060	01.1051	150122	01.0547
140165	00.9312	140226	00.9529	150006	01.1682	150061	01.1022	150123	01.0724
140166	01.1024	140228	01.3420	150007	01.0889	150062	01.0325	150124	01.1327
140167	01.0373	140229	01.0743	150008	01.2743	150063	01.1226	150125	01.1383
140168	01.0203	140230	00.9940	150009	01.1214	150064	01.0703	150126	01.6537
140170	01.0698	140231	01.1667	150010	01.0421	150065	01.1262	150127	01.0770
140171	00.9528	140232	01.0248	150011	01.1248	150066	01.0944	150128	01.1297
140172	01.2570	140233	01.4368	150012	01.2780	150067	01.0454	150129	01.0870

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
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TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
150130	01.1951	160053	01.1480	160109	01.0990	170016	01.4458	170074	01.1042
150132	01.2628	160054	01.0816	160110	01.3297	170017	01.0977	170075	00.9059
150133	01.1437	160055	01.0664	160111	01.1558	170018	01.0575	170076	01.1100
150134	01.1661	160056	01.0082	160112	01.2131	170019	01.2075	170077	00.9716
150135	00.8478	160057	01.1687	160113	01.0525	170020	01.1610	170079	00.9020
150136	00.9962	160058	01.4173	160114	01.0433	170021	00.9498	170080	00.9680
160001	01.1520	160059	01.1866	160115	01.0691	170022	01.1318	170081	01.0858
160002	01.1993	160060	01.0786	160116	01.1197	170023	01.2417	170082	00.9512
160003	01.0765	160061	01.0093	160117	01.2883	170024	01.0075	170084	00.9952
160004	01.1239	160062	01.0531	160118	01.0968	170025	01.0795	170085	01.0103
160005	01.1407	160063	01.0949	160119	00.9511	170026	01.0106	170086	01.4628
160007	01.0754	160064	01.2002	160120	00.9142	170027	01.0373	170087	01.2049
160008	01.1272	160065	01.1334	160122	01.0650	170030	01.0139	170088	01.0050
160009	01.1705	160066	01.0780	160123	00.9963	170031	01.0230	170089	01.0095
160012	01.0916	160067	01.1344	160124	01.1878	170032	01.0759	170090	01.0846
160013	01.2138	160068	01.1022	160126	01.1018	170033	01.1027	170092	01.0704
160014	01.0401	160069	01.3035	160129	01.0304	170034	00.9572	170093	00.9620
160016	01.2295	160070	01.0192	160130	01.1149	170035	00.9567	170094	00.8942
160018	01.0719	160071	01.1318	160131	01.1165	170036	00.9756	170095	01.0661
160020	01.0535	160072	01.1164	160132	01.0527	170037	01.1090	170097	00.9993
160021	01.1000	160073	00.9227	160133	01.1187	170038	01.0001	170098	01.0153
160023	01.0994	160074	00.9924	160134	00.9392	170039	01.0795	170099	01.0825
160024	01.1912	160075	01.0124	160135	00.9839	170040	01.3076	170100	00.8971
160025	01.4810	160076	01.0029	160136	01.0327	170041	01.0036	170101	01.0344
160026	01.1180	160077	01.0408	160138	01.0069	170043	01.1573	170102	01.0270
160027	01.1221	160079	01.2312	160140	01.0329	170044	00.9825	170103	01.1872
160028	01.1008	160080	01.1126	160141	01.0405	170045	01.0292	170104	01.2611
160029	01.2223	160081	01.1224	160142	01.1031	170046	00.9922	170105	01.0020
160030	01.2134	160082	01.4484	160143	01.1070	170049	01.1641	170106	01.0149
160031	01.0769	160083	01.4324	160145	01.0815	170050	00.9566	170108	00.9361
160032	01.0317	160085	01.1947	160146	01.2182	170051	00.9885	170109	01.0270
160033	01.2219	160086	01.0206	160147	01.2299	170052	01.0113	170110	00.9487
160034	01.0482	160088	01.0728	160151	01.1491	170053	00.9724	170112	01.0008
160035	01.0769	160089	01.1728	160152	01.0490	170054	00.9948	170113	01.0677
160036	01.1267	160090	01.0351	160153	01.3630	170055	00.9177	170114	01.0279
160037	01.1212	160091	01.1313	170001	01.1331	170056	01.0007	170115	01.0127
160038	01.1372	160092	01.0606	170002	01.1622	170057	00.9387	170116	01.1378
160039	01.0612	160093	00.9497	170003	01.0946	170058	01.0260	170117	01.0387
160040	01.1726	160094	01.1081	170004	01.0707	170060	00.9875	170119	00.9407
160041	01.0312	160095	01.0247	170005	00.9270	170061	01.0703	170120	01.1089
160043	01.0411	160097	01.1106	170006	01.1203	170062	00.9690	170121	00.8922
160044	01.2424	160098	01.1223	170007	01.1559	170063	00.9516	170122	01.6072
160045	01.3685	160099	01.0937	170008	00.9669	170064	00.9557	170123	01.3110
160046	01.0615	160101	01.1209	170009	01.0956	170066	00.9456	170124	00.9421
160047	01.2521	160102	01.2579	170010	01.0516	170067	01.0713	170125	00.9456
160048	01.1004	160103	00.9273	170011	01.1226	170068	01.0867	170126	00.9317
160049	01.0301	160104	01.0257	170012	01.3149	170069	01.0598	170128	00.9661
160050	01.0582	160106	01.1347	170013	01.1526	170070	00.9891	170130	01.0597
160051	01.0748	160107	01.1114	170014	01.0601	170072	00.9842	170131	01.1815
160052	01.0723	160108	01.1773	170015	01.0487	170073	01.1880	170133	01.2131

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
170134	00.9879	180026	01.0209	180093	01.2176	190019	01.2921	190106	00.9939
170137	01.1537	180027	01.0146	180094	00.9694	190020	01.0488	190109	01.0779
170138	01.1492	180028	00.9270	180095	01.0573	190023	00.9277	190110	00.9812
170139	01.0188	180029	01.0634	180099	00.9452	190025	01.0676	190111	01.2961
170140	00.9918	180030	00.9748	180100	01.1366	190026	01.1722	190112	01.1852
170142	01.1185	180031	01.0176	180101	01.0981	190027	01.2042	190113	01.0903
170143	01.1488	180032	00.9037	180102	01.1715	190029	01.1268	190114	00.8830
170144	01.2959	180033	00.9704	180103	01.3587	190033	00.9232	190115	01.1990
170145	01.0881	180034	00.9500	180104	01.2561	190034	01.1030	190116	01.0744
170146	01.2558	180035	01.1742	180105	00.8971	190035	01.2438	190117	00.9983
170147	01.1171	180036	01.0147	180106	00.8963	190036	01.3964	190118	01.0185
170148	01.1656	180037	01.1650	180108	00.8795	190037	00.9189	190119	00.9636
170150	01.0994	180038	01.1338	180114	00.9730	190039	01.2887	190120	00.9552
170151	00.9890	180040	01.4352	180115	00.9524	190040	01.2121	190122	01.1563
170152	00.9043	180041	00.9847	180116	01.1059	190041	01.2952	190124	01.2030
170159	00.9932	180042	01.0274	180117	00.9325	190043	01.0836	190125	01.1952
170160	00.9161	180043	01.0163	180118	00.9912	190044	01.0371	190127	01.0647
170164	01.1490	180044	00.9825	180120	00.9456	190045	01.0951	190128	00.9849
170166	01.0221	180045	01.1159	180121	01.0410	190046	01.2725	190130	00.9363
170168	00.9812	180046	01.0111	180122	00.8968	190047	01.0063	190131	01.0220
170170	01.1787	180047	01.0063	180123	01.1680	190048	01.0248	190132	01.0274
170171	01.0902	180048	01.1275	180124	01.1604	190049	00.9674	190133	01.1067
170172	00.9800	180049	01.0814	180125	00.9108	190050	00.9843	190134	00.8943
170173	00.9079	180050	01.0577	180126	00.9593	190053	01.0984	190135	01.2929
170174	00.9425	180051	01.1267	180127	01.0805	190054	01.1674	190136	00.9580
170175	01.0991	180053	00.9952	180128	01.0448	190058	00.9788	190137	00.9934
170176	01.2131	180054	01.0802	180129	00.9731	190059	01.0602	190138	00.6755
170178	00.9707	180055	01.0435	180130	01.1722	190060	01.1433	190139	01.0288
180001	01.1353	180056	01.0666	180132	01.0628	190064	01.2281	190140	00.9847
180002	01.0015	180058	00.8828	180133	01.1601	190065	01.2824	190141	01.0069
180004	01.0346	180059	00.9324	180134	01.0362	190067	01.0166	190142	00.9822
180005	01.0028	180060	00.9474	180136	01.1829	190071	00.9921	190144	01.0605
180006	00.9439	180062	00.9307	180137	01.2364	190073	00.8999	190145	01.0191
180007	01.1569	180063	00.9506	190001	00.9663	190075	01.1174	190146	01.3506
180009	01.0978	180064	01.0111	190002	01.3695	190077	01.0082	190147	00.9987
180010	01.4626	180065	00.9781	190003	01.0941	190078	01.0073	190148	00.9100
180011	00.9942	180066	00.9868	190004	01.1437	190079	01.0701	190149	00.9838
180012	01.1171	180067	01.3913	190005	01.1424	190081	00.9450	190151	01.0638
180013	01.1293	180069	00.9783	190006	01.0877	190083	00.9523	190152	01.0975
180014	01.4177	180070	00.9623	190007	01.0136	190086	01.1099	190155	00.9808
180015	01.0356	180072	01.0543	190008	01.2649	190088	01.0091	190156	00.9304
180016	01.1236	180075	00.9416	190009	01.1050	190089	01.0403	190157	00.9434
180017	01.1397	180078	00.9675	190010	01.0174	190090	01.0523	190158	01.0922
180018	01.1030	180079	00.9958	190011	01.0435	190092	01.1038	190160	01.0093
180019	01.0927	180080	01.0456	190012	00.9399	190095	00.9375	190161	01.0496
180020	00.9626	180081	01.1333	190013	01.0937	190098	01.2857	190162	01.0784
180021	00.9576	180085	01.1558	190014	01.0087	190099	01.0429	190163	00.9702
180023	00.9007	180087	01.0081	190015	01.0783	190101	00.9838	190164	01.0581
180024	00.9953	180088	01.2641	190017	01.0810	190102	01.2521	190165	01.0544
180025	01.0830	180092	01.0436	190018	01.0689	190103	00.8289	190166	00.9071

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
190167	01.0227	200020	01.0505	210023	01.1641	220020	01.1419	220081	01.0305
190169	00.8773	200021	01.1171	210024	01.1937	220021	01.1311	220082	01.1544
190170	01.0274	200023	00.9873	210025	01.0904	220022	01.0858	220083	01.1674
190173	01.1643	200024	01.1907	210026	01.1555	220023	01.1828	220084	01.1192
190175	01.1232	200025	01.1255	210027	01.1620	220024	01.1921	220086	01.4669
190176	01.3483	200026	01.0329	210028	01.0508	220025	01.1150	220087	00.8846
190177	01.0378	200027	01.0811	210029	01.2525	220026	01.2552	220088	01.4155
190178	00.9734	200028	01.0128	210030	01.0343	220028	01.1970	220089	01.2162
190179	01.0088	200031	01.1460	210031	01.5134	220029	01.1067	220090	01.1460
190180	01.0477	200032	01.2073	210032	01.0628	220030	01.0527	220092	01.1644
190182	00.9667	200033	01.3282	210033	01.1562	220031	01.4805	220094	01.1242
190183	01.1289	200034	01.1263	210034	01.1064	220033	01.1612	220095	01.1220
190184	00.9523	200037	01.1309	210035	01.1196	220034	01.1081	220097	01.0071
190185	01.0988	200038	01.0562	210036	01.1927	220035	01.1144	220098	01.1273
190186	00.9290	200039	01.2308	210037	01.1463	220036	01.3319	220099	01.0766
190187	01.0874	200040	01.0716	210038	01.1694	220038	01.0936	220100	01.2341
190188	00.9243	200041	01.0472	210039	01.0865	220040	01.2141	220101	01.1705
190189	01.1349	200043	00.9233	210040	01.1904	220041	01.1597	220102	00.8446
190190	00.9402	200044	01.0987	210041	01.1408	220042	01.1171	220104	01.1169
190191	01.1402	200047	01.0819	210042	01.1636	220045	01.1481	220105	01.0890
190193	01.1556	200049	00.9608	210043	01.0986	220046	01.2576	220106	01.1088
190194	01.0326	200050	01.1120	210044	01.1600	220048	01.1368	220107	01.0341
190195	00.9641	200051	00.9682	210045	01.0252	220049	01.1131	220108	01.1069
190196	00.9751	200052	01.0075	210046	01.0226	220050	01.0155	220110	01.7326
190197	01.1914	200055	01.0370	210047	01.0373	220051	01.1943	220111	01.1412
190198	01.0713	200056	00.5558	210048	01.1337	220052	01.1698	220114	01.0909
190199	01.0367	200058	00.8740	210049	01.1775	220053	01.1523	220115	01.1847
190200	01.0483	200062	01.0292	210050	01.0351	220055	01.1834	220116	01.5872
190201	00.7681	200063	01.2288	210051	01.1815	220057	01.1450	220117	01.0591
190202	01.1828	200066	01.1005	210054	01.1223	220058	01.0693	220118	01.6940
190203	01.2231	210001	01.2432	210055	01.1521	220060	01.1011	220119	01.1891
190204	01.1635	210002	01.4210	210056	01.2940	220061	01.1192	220120	01.0214
190205	01.1104	210003	01.1560	210057	01.2219	220062	00.7251	220121	01.0463
190206	01.4427	210004	01.1986	210058	01.5956	220063	01.1268	220123	01.0219
190207	01.0915	210005	01.2248	210059	01.0951	220064	01.1688	220126	01.2324
200001	01.2589	210006	01.0668	220001	01.1459	220065	01.1456	220128	01.0894
200002	01.0483	210007	01.4034	220002	01.2956	220066	01.2064	220129	01.1351
200003	01.0253	210008	01.1630	220003	01.0218	220067	01.1922	220131	01.0719
200005	00.9819	210009	01.3329	220004	01.1477	220068	00.8827	220133	00.8870
200006	01.0152	210010	01.1254	220005	01.0832	220069	00.9844	220135	01.1390
200007	00.9808	210011	01.2465	220006	01.1671	220070	01.1541	220153	00.9945
200008	01.2041	210012	01.1753	220008	01.1490	220071	01.5347	220154	01.0449
200009	01.5340	210013	01.1879	220009	01.1213	220072	01.0842	220156	01.1659
200012	01.1051	210015	01.1769	220010	01.1039	220073	01.1674	220163	01.7091
200013	01.1200	210016	01.4070	220011	01.1662	220074	01.0980	220171	01.3332
200015	01.2124	210017	01.0885	220012	01.2176	220075	00.6808	230001	01.0718
200016	01.0686	210018	01.2075	220015	01.1659	220076	01.1496	230002	01.1325
200017	01.1511	210019	01.2945	220016	01.1491	220077	01.3311	230003	01.1063
200018	01.1018	210021	01.1936	220017	01.2096	220079	01.0605	230004	01.3910
200019	01.1745	210022	01.2092	220019	01.1266	220080	01.1309	230005	01.1141

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
230006	01.1008	230075	01.1246	230135	01.1126	230201	00.9518	240007	01.0898
230007	01.0446	230076	01.2337	230137	01.0282	230203	00.8228	240008	01.0507
230008	01.2103	230077	01.5246	230138	00.9439	230204	01.2258	240009	01.0350
230011	01.1130	230078	01.0375	230140	01.0768	230205	01.1285	240010	01.7994
230012	01.1531	230080	01.1420	230141	01.2889	230207	01.0707	240011	01.0288
230013	01.1583	230081	01.0586	230142	01.0900	230208	01.1953	240013	01.1911
230014	00.9930	230082	01.0655	230143	01.1955	230211	00.9627	240014	01.0596
230015	01.0912	230084	01.1352	230144	01.1183	230212	01.0611	240016	01.2414
230017	01.2510	230085	01.0764	230145	01.0745	230213	00.9771	240017	01.2068
230019	01.2067	230086	01.0244	230146	01.1205	230216	01.1740	240018	01.1501
230020	01.2103	230087	01.0379	230147	01.1304	230217	00.9973	240019	01.3498
230021	01.2626	230089	01.1585	230149	01.1095	230219	00.9291	240020	01.1459
230022	01.1811	230090	01.1399	230150	01.4509	230221	01.1621	240021	01.0543
230024	01.3685	230092	01.1643	230151	01.2549	230222	01.1206	240022	01.0566
230027	01.0447	230093	01.1467	230153	01.0864	230223	01.1978	240023	01.0346
230029	01.2003	230095	01.0551	230154	01.0679	230224	01.0616	240024	01.1417
230030	01.1595	230096	01.1031	230155	00.9962	230225	01.0431	240025	01.1349
230031	01.2678	230097	01.1506	230156	01.4195	230227	01.1714	240026	01.2859
230032	01.4966	230098	01.1142	230157	01.1869	230228	01.1375	240027	01.0409
230034	01.0449	230099	01.0835	230158	01.0886	230230	01.1930	240028	01.1229
230035	00.9938	230100	01.0907	230159	01.1247	230231	00.9838	240029	01.1037
230036	01.1842	230101	01.0964	230161	00.9060	230232	00.9702	240030	01.3310
230037	01.0518	230102	01.1944	230162	00.9159	230235	00.9555	240031	00.9651
230038	01.4999	230103	01.0322	230163	00.9439	230236	01.2392	240033	00.9914
230039	01.1579	230104	01.2806	230165	01.3818	230237	01.2309	240036	01.2808
230040	01.1284	230105	01.3397	230167	01.1119	230238	01.0762	240037	01.1605
230041	01.0922	230106	01.0681	230169	01.1507	230239	01.0537	240038	01.4288
230042	01.1259	230107	01.0645	230171	01.0678	230241	01.0401	240040	01.1327
230043	00.9413	230108	01.1172	230172	01.1208	230244	01.1745	240041	01.1399
230046	01.5014	230110	01.1156	230173	01.0912	230253	01.0850	240043	01.1719
230047	01.0990	230111	00.9629	230174	01.1489	230254	01.1468	240044	01.1618
230051	00.9816	230113	00.8752	230175	00.9290	230256	01.0338	240045	01.0868
230053	01.3061	230114	00.9875	230176	01.0881	230257	01.0332	240046	01.2741
230054	01.3325	230115	01.0295	230177	01.0658	230258	00.9755	240047	01.2719
230055	01.0585	230116	00.9279	230178	01.0085	230259	00.9956	240048	01.1283
230056	00.9698	230117	01.6631	230179	01.0006	230264	01.1216	240049	01.4353
230057	01.0308	230118	01.1332	230180	01.0277	230265	01.1906	240050	01.0669
230058	01.0907	230119	01.1310	230181	01.0067	230266	01.0802	240051	01.0879
230059	01.3122	230120	01.0315	230183	01.1268	230269	01.1351	240052	01.1997
230060	01.1290	230121	01.0865	230184	01.0866	230270	01.1422	240053	01.3207
230062	01.0848	230122	01.2040	230186	00.9800	230273	01.1338	240055	01.2454
230063	01.1895	230123	00.8803	230188	01.0864	230275	00.7395	240056	01.2509
230065	01.1762	230124	01.0588	230189	00.9393	230276	00.7347	240057	01.6221
230066	01.1578	230125	01.2593	230190	01.2043	230277	01.1137	240058	00.9656
230067	00.9628	230128	01.2337	230191	00.9042	240001	01.3446	240059	01.0981
230068	01.1974	230129	01.5610	230193	01.1348	240002	01.4228	240061	01.3959
230069	01.0995	230130	01.3117	230194	01.1510	240003	01.1547	240062	01.1595
230070	01.1808	230132	01.1791	230195	01.1595	240004	01.3043	240063	01.2854
230071	00.7442	230133	01.0884	230197	01.0905	240005	00.9571	240064	01.1890
230072	01.1311	230134	00.9917	230199	01.0523	240006	01.1191	240065	00.9371

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TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
240066	01.2096	240123	01.0693	240184	01.0317	250041	01.0188	250104	00.9897
240069	01.0696	240124	01.0624	240187	01.1845	250042	01.0452	250105	00.9350
240071	01.0671	240125	00.9818	240192	01.0501	250043	00.8603	250107	00.9202
240072	01.0129	240127	01.0610	240193	01.1290	250044	00.9589	250109	00.9615
240073	00.9895	240128	01.0735	240194	01.1336	250045	01.0007	250110	00.9306
240074	01.0587	240129	00.9903	240195	00.8374	250046	00.9822	250111	00.8924
240075	01.1466	240130	00.9948	240196	01.3973	250047	00.9270	250112	00.9167
240076	01.1804	240131	01.2340	240200	00.9938	250048	01.2859	250113	00.9983
240077	01.0135	240132	01.2353	240201	00.9255	250049	00.9038	250114	00.8822
240078	01.3130	240133	01.0876	240205	00.8910	250050	01.1690	250117	00.9710
240079	01.0670	240134	01.1242	240206	00.9465	250051	00.8754	250118	01.0343
240080	01.2262	240135	00.9239	240207	01.1696	250057	01.0138	250119	00.9021
240081	01.2625	240136	01.1071	240208	01.0055	250058	01.0883	250120	01.0516
240082	01.1924	240137	01.1100	240210	01.2355	250059	01.0147	250121	00.9918
240083	01.2473	240138	01.0589	250001	01.3281	250060	00.8566	250122	01.0176
240084	01.2106	240139	01.0640	250002	00.8335	250061	01.0100	250123	01.1167
240085	00.8947	240140	00.8812	250003	00.8832	250062	01.0213	250124	00.8882
240086	01.1068	240141	01.0495	250004	01.2306	250063	00.8831	250125	01.0796
240087	01.0740	240142	01.2132	250005	00.9160	250065	00.9618	250126	00.9858
240088	01.3352	240143	00.9987	250006	00.9375	250066	00.9389	250127	00.8888
240089	01.1180	240144	01.0444	250007	01.0565	250067	01.1092	250128	00.9531
240090	01.0762	240145	00.9955	250008	00.8984	250068	00.8703	250129	01.0006
240091	00.9729	240146	01.0674	250009	01.0850	250069	01.0728	250131	01.0479
240093	01.2771	240148	00.9493	250010	00.9477	250071	00.9927	250132	00.9269
240094	01.2554	240150	00.9411	250012	00.9103	250072	01.0839	250133	00.8566
240096	01.1043	240152	01.0467	250014	00.9978	250073	00.8652	250134	01.0354
240097	01.1481	240153	01.0182	250015	00.9813	250075	00.9640	250136	00.8254
240098	00.9850	240154	01.0322	250016	00.8736	250076	00.8369	250137	00.8875
240099	01.0352	240155	01.0117	250017	00.9203	250077	00.9180	250138	01.0197
240100	01.2058	240156	01.0222	250018	00.9777	250078	01.2279	250139	00.9189
240101	01.0872	240157	01.0253	250019	01.0953	250079	00.8728	250140	00.8972
240102	00.9964	240158	01.0569	250020	00.9601	250081	01.1048	260001	01.3820
240103	01.1584	240160	01.0750	250021	00.9835	250082	01.1157	260002	01.1417
240104	01.1802	240161	01.0280	250023	00.9101	250083	00.8604	260003	01.0119
240105	00.9810	240162	01.1670	250024	00.9353	250084	01.0592	260004	01.0183
240106	01.1966	240163	00.9890	250025	00.9507	250085	00.9652	260005	01.1305
240107	01.0659	240165	01.2593	250026	00.8846	250086	00.9316	260006	01.1685
240108	01.0306	240166	01.1165	250027	00.9613	250088	01.0154	260007	01.1195
240109	01.0303	240167	00.9839	250029	00.9134	250089	00.9597	260008	01.1843
240110	01.0546	240169	01.0309	250030	00.9220	250091	00.9688	260009	01.1062
240111	01.0232	240170	01.0821	250031	01.0379	250093	01.0999	260010	01.1192
240112	01.0523	240171	01.0507	250032	01.1091	250094	01.0955	260011	01.1677
240114	01.0574	240172	01.0336	250033	00.8646	250095	00.9794	260012	00.9278
240115	01.2493	240173	01.0343	250034	01.1133	250096	01.0915	260013	01.0485
240116	00.9588	240175	01.0019	250035	00.9145	250097	01.0427	260014	01.3451
240117	01.0952	240176	01.0567	250036	00.9652	250098	00.8884	260015	01.0379
240118	00.9206	240177	01.0388	250037	00.9154	250099	01.0310	260016	01.1747
240119	00.9883	240179	01.0166	250038	00.8938	250100	01.1756	260017	01.1872
240121	01.1078	240180	01.0593	250039	00.9477	250101	00.8888	260018	00.9875
240122	01.0187	240183	01.0353	250040	01.0538	250102	01.3228	260019	01.0692

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TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
260020	01.3168	260080	01.0092	260158	01.1015	270029	00.9439	280015	00.9680
260021	01.2217	260081	01.2838	260159	01.0373	270030	00.8943	280017	01.0660
260022	01.1773	260082	01.1046	260160	01.0617	270031	00.8905	280018	01.0109
260023	01.1482	260083	01.0617	260162	01.1841	270032	01.0685	280020	01.2340
260024	01.0779	260085	01.1852	260163	01.1373	270033	00.9352	280021	01.2465
260025	01.1103	260086	01.0661	260164	01.0823	270035	00.9743	280022	00.9712
260026	01.0072	260088	01.1018	260165	01.0734	270036	01.0307	280023	01.1872
260027	01.2739	260089	01.0845	260166	01.1232	270039	00.9306	280024	00.9033
260029	01.0905	260090	01.2036	260171	01.0028	270040	01.0808	280025	00.9559
260030	01.0639	260091	01.2857	260172	01.0073	270041	00.9605	280026	00.9595
260031	01.4318	260092	01.0116	260173	01.1621	270042	00.8031	280028	00.9608
260032	01.3860	260093	01.0893	260175	01.0978	270043	00.8568	280029	01.2551
260033	01.1969	260094	01.0503	260176	01.2362	270044	00.9771	280030	01.3984
260034	01.0349	260095	01.1604	260177	01.1946	270046	00.8722	280031	01.0568
260035	00.9708	260096	01.2673	260178	01.2539	270047	00.9010	280032	01.1981
260036	01.0628	260097	01.1246	260179	01.3517	270048	01.0111	280033	01.0143
260037	01.1424	260100	01.1395	260180	01.3155	270049	01.3105	280034	01.2097
260039	01.0870	260102	01.0002	260182	01.0571	270050	00.9892	280035	01.0120
260040	01.3343	260103	01.1927	260183	01.1900	270051	01.1114	280037	01.0852
260041	00.9849	260104	01.3120	260186	01.0516	270052	00.8954	280038	01.1419
260042	01.0637	260105	01.6961	260188	01.1335	270053	00.9546	280039	01.0586
260044	01.0890	260107	01.1758	260189	00.9874	270055	00.8815	280040	01.3941
260045	00.9953	260108	01.4768	260190	01.1291	270057	01.1466	280041	01.0175
260047	01.1499	260109	00.9541	260191	01.1712	270058	01.0651	280042	01.0533
260048	01.1468	260110	01.2914	260192	00.7714	270059	00.9004	280043	01.0175
260049	00.9133	260111	01.0335	260193	01.1433	270060	00.9052	280045	01.0746
260050	01.0540	260112	01.2841	260195	01.0355	270063	00.9477	280046	01.0592
260051	01.1053	260113	01.0991	260197	01.0987	270067	00.9579	280047	01.1472
260052	01.1348	260115	00.9989	270001	00.8802	270068	00.9688	280048	01.0199
260053	01.0741	260116	01.1043	270002	01.0534	270071	00.8360	280049	01.0152
260054	01.1744	260118	01.1862	270003	01.1275	270072	00.8664	280050	01.0351
260055	01.0464	260119	01.1442	270004	01.5349	270073	01.1151	280051	00.9641
260056	01.1314	260120	01.1273	270006	01.0794	270074	00.8577	280052	01.0490
260057	01.0204	260121	00.9751	270007	00.9353	270075	00.9345	280054	01.0935
260058	01.1919	260122	01.0741	270008	00.8671	270076	00.8944	280055	01.0080
260059	00.9905	260123	01.0182	270009	00.9098	270079	00.9486	280056	01.1063
260061	01.0840	260127	01.0838	270011	01.0717	270080	01.0541	280057	01.0487
260062	01.1241	260128	00.9786	270012	01.2813	270081	00.9655	280058	01.1476
260063	01.1261	260129	01.1513	270013	01.1800	270082	00.9255	280060	01.2189
260064	01.1545	260131	01.2379	270014	01.5589	270083	01.1293	280061	01.2050
260065	01.3123	260133	01.0102	270016	00.9756	280001	01.0719	280062	01.0996
260066	01.0349	260134	01.0808	270017	01.1485	280003	01.5278	280063	01.0211
260067	00.9952	260137	01.1748	270018	00.9970	280004	01.0802	280064	01.0551
260068	01.6465	260138	01.6409	270019	00.9279	280005	01.2198	280065	01.1661
260070	01.0112	260141	01.5723	270021	01.0091	280009	01.2077	280066	01.0375
260073	00.9665	260142	01.1375	270023	01.2328	280010	01.1819	280068	00.9769
260074	01.0744	260143	01.2287	270024	01.0223	280011	01.0739	280070	01.0075
260077	01.1731	260146	00.8490	270026	00.8792	280012	01.2223	280071	00.9863
260078	01.0687	260147	01.0654	270027	00.9885	280013	01.3516	280073	00.9968
260079	01.0566	260148	00.9688	270028	01.0202	280014	00.9680	280074	01.0757

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
280075	01.1067	290012	01.2479	310008	01.1900	310063	01.1877	320016	01.0167
280076	01.0586	290013	01.0339	310009	01.1213	310064	01.1642	320017	01.0898
280077	01.1993	290014	01.0384	310010	01.1700	310067	01.1646	320018	01.1196
280078	01.0107	290015	00.9170	310011	01.1878	310068	01.1300	320019	01.2393
280079	00.9427	290016	01.0762	310012	01.2021	310069	01.0864	320021	01.5290
280080	00.9809	290018	00.8930	310013	01.1517	310070	01.1992	320022	01.1838
280081	01.2452	290019	01.1584	310014	01.2791	310071	01.0920	320023	01.0166
280082	00.9271	290020	00.9106	310015	01.2234	310072	01.2033	320030	01.0046
280083	01.0672	290021	01.4088	310016	01.1152	310073	01.1682	320031	00.9415
280084	00.9742	290022	01.4411	310017	01.1305	310074	01.1745	320032	00.9980
280085	01.1762	290027	00.9592	310018	01.1198	310075	01.1724	320033	01.1596
280087	01.2378	290028	01.0222	310019	01.4987	310076	01.1995	320035	00.9224
280088	01.3550	290029	00.8264	310020	01.1300	310077	01.3784	320037	01.1275
280089	00.9439	290031	01.2329	310021	01.1486	310078	01.1128	320038	01.0841
280090	00.9859	290032	01.2411	310022	01.1515	310081	01.1536	320046	01.0694
280091	01.0353	290033	01.0877	310024	01.1344	310083	01.1422	320048	01.0583
280092	00.9559	290034	00.8064	310025	01.1076	310084	01.1710	320049	01.0544
280093	00.8961	300001	01.1785	310026	01.1981	310085	01.1554	320051	01.0541
280094	01.0240	300002	01.0795	310027	01.1632	310086	01.1785	320053	00.9684
280097	01.0074	300003	01.4897	310028	01.0897	310087	01.1296	320056	00.8768
280098	00.9557	300005	01.1939	310029	01.5526	310088	01.1153	320057	01.1226
280101	01.0333	300006	01.0634	310031	02.3912	310090	01.1734	320058	01.0070
280102	00.9964	300007	01.0807	310032	01.0786	310091	01.1432	320059	01.1091
280103	01.0092	300008	01.0829	310033	01.0607	310092	01.1564	320060	00.9382
280104	00.9775	300009	01.0940	310034	01.1333	310093	01.0459	320061	01.0756
280105	01.1451	300010	01.1130	310036	01.1510	310094	01.0824	320062	00.8829
280106	01.0176	300011	01.1413	310037	01.1622	310096	01.3396	320063	01.1130
280107	00.9857	300012	01.1575	310038	01.4069	310105	01.0592	320065	01.0928
280108	01.0552	300013	01.0656	310039	01.1380	310108	01.1590	320066	00.8144
280109	00.9795	300014	01.1685	310040	01.1177	310110	01.1514	320067	00.9175
280110	01.0601	300015	01.0944	310041	01.1714	310111	01.1755	320068	01.1013
280111	01.0940	300016	01.0207	310042	01.1117	310112	01.1318	320069	01.0618
280114	01.0237	300017	01.2317	310043	01.1502	310113	01.1308	320070	01.0811
280115	01.1212	300018	01.1704	310044	01.1640	310115	01.1184	320071	00.9589
280116	00.9959	300019	01.0844	310045	01.1500	310116	01.1907	320073	01.0242
280117	01.0559	300020	01.1179	310047	01.2486	310118	01.1227	320074	01.1753
280118	01.0382	300021	01.0708	310048	01.1483	310119	01.1538	320075	00.4694
280119	00.8833	300022	01.0850	310049	01.1240	310120	01.0789	320076	01.1093
280122	00.7806	300023	01.1135	310050	01.1000	320001	01.2802	320077	00.9319
280123	00.6417	300024	01.1798	310051	01.2425	320002	01.1677	330001	01.1311
290001	01.3334	300028	01.0977	310052	01.1686	320003	01.1416	330002	01.1614
290002	00.9473	300029	01.1603	310053	01.1430	320004	01.0824	330003	01.2051
290003	01.3143	300032	00.9677	310054	01.2512	320005	01.1729	330004	01.1056
290005	01.1492	300033	01.0260	310056	01.2000	320006	01.1239	330005	01.3811
290006	00.9868	300034	01.2223	310057	01.2116	320009	01.1940	330006	01.2095
290007	01.3911	310001	01.3657	310058	01.0244	320010	01.1732	330007	01.1269
290008	01.1678	310002	01.6813	310059	00.8416	320011	01.0240	330008	01.1119
290009	01.2943	310003	01.1171	310060	01.2126	320012	01.0141	330009	01.0237
290010	01.0053	310005	01.1342	310061	01.1120	320013	01.0072	330010	01.1017
290011	01.0150	310006	01.1287	310062	00.9929	320014	00.9671	330011	01.1267

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330012	01.2304	330079	01.1947	330153	01.1682	330215	01.1111	330286	01.1459
330013	01.5889	330080	01.0735	330155	01.1113	330217	01.0140	330288	01.0405
330014	01.1573	330082	01.1337	330157	01.1593	330218	01.0868	330290	01.3487
330015	01.1232	330084	01.0013	330158	01.1491	330219	01.2422	330291	01.0219
330016	01.0042	330085	01.2404	330159	01.2268	330221	01.1693	330293	01.0500
330019	01.1183	330086	01.1255	330160	01.1460	330222	01.1142	330297	01.0541
330020	01.0363	330088	01.1540	330161	01.0499	330223	00.9925	330304	01.1485
330022	01.0341	330090	01.3994	330162	01.1959	330224	01.1348	330306	01.1977
330023	01.1418	330091	01.1319	330163	01.0597	330225	01.0849	330307	01.0875
330024	01.4331	330092	01.0430	330164	01.2593	330226	01.1275	330308	01.0822
330025	00.9976	330094	01.1589	330165	01.0397	330229	01.1402	330309	01.1059
330027	01.1852	330095	01.1127	330166	01.0421	330230	01.1805	330314	01.1433
330028	01.1332	330096	01.0218	330167	01.3033	330231	01.0509	330315	01.0955
330029	01.1320	330097	01.0411	330168	01.0456	330232	01.1387	330316	01.2144
330030	01.0081	330100	00.5919	330169	01.1823	330233	01.1503	330318	01.0853
330033	01.1345	330101	01.3711	330171	01.1860	330234	01.7522	330320	01.1043
330034	01.1207	330102	01.1875	330174	01.0418	330235	01.1438	330323	01.6497
330036	01.0350	330103	01.1659	330175	01.0510	330236	01.1838	330327	00.9632
330037	01.0513	330104	01.1631	330176	00.9275	330238	01.0780	330331	01.0808
330038	01.0484	330106	01.3882	330177	01.0332	330239	01.0794	330332	01.0684
330039	01.0573	330107	01.1488	330179	00.9221	330240	01.0481	330333	01.0728
330041	01.0737	330108	01.1676	330180	01.1433	330241	01.5537	330335	01.0953
330043	01.1235	330109	00.9164	330181	01.1556	330242	01.1440	330336	01.1091
330044	01.1581	330110	00.9690	330182	02.0333	330244	01.0607	330338	01.0680
330045	01.1444	330111	01.1181	330183	01.2888	330245	01.1738	330339	00.8723
330046	01.1940	330114	00.9891	330184	01.1354	330246	01.1255	330340	01.0466
330047	01.1217	330115	01.0806	330185	01.1066	330247	00.5891	330345	00.8321
330048	01.0977	330116	01.0178	330186	01.0915	330249	01.1233	330350	01.4705
330049	01.1844	330117	01.1679	330188	01.1238	330250	01.0952	330351	01.0256
330050	01.0429	330118	01.2423	330189	00.6248	330252	00.9203	330353	01.0976
330052	01.0862	330119	01.2047	330191	01.1173	330254	01.0155	330357	01.1464
330053	01.0480	330120	01.4147	330193	01.2045	330256	00.9422	330359	01.0037
330055	01.1943	330121	01.0507	330194	01.3579	330257	01.0301	330361	00.9907
330056	01.1771	330122	01.0813	330195	01.3372	330258	01.1063	330362	00.9365
330057	01.2622	330125	01.4570	330196	01.1615	330259	01.1512	330363	00.9251
330058	01.1238	330126	01.0874	330197	01.0342	330261	01.1613	330366	00.9222
330059	01.3157	330127	01.1035	330198	01.1722	330263	01.0055	330367	00.9296
330061	01.1592	330128	01.1575	330199	01.1074	330264	01.0484	330368	00.9312
330062	00.9540	330132	01.0851	330201	01.1844	330265	01.1880	330369	00.9299
330064	01.1618	330133	01.0764	330202	01.1123	330267	01.1219	330371	00.9729
330065	01.1133	330135	01.1401	330203	01.2803	330268	01.1520	330372	01.1103
330066	01.0834	330136	01.2150	330204	01.1097	330270	01.6647	330373	01.0466
330067	01.1715	330140	01.3431	330205	01.0554	330272	00.9753	330381	01.0158
330072	01.2091	330141	01.1170	330208	01.1149	330273	01.0434	330383	01.1151
330073	01.0923	330142	01.1543	330209	01.0887	330275	01.1224	330385	01.0685
330074	01.1116	330144	01.0212	330210	01.0435	330276	01.0913	330386	01.1195
330075	01.0521	330148	01.0278	330211	01.0733	330277	01.0963	330387	00.9628
330076	01.0962	330150	00.9196	330212	01.0916	330279	01.1223	330389	01.5726
330077	01.0844	330151	01.0693	330213	01.0222	330281	00.7570	330390	01.1072
330078	01.2233	330152	01.2081	330214	01.4890	330285	01.4121	330391	01.5397

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330393	01.3644	340048	00.8039	340119	01.2073	350013	00.9864	360010	01.0980
330394	01.1879	340049	00.6967	340120	01.0624	350014	00.9775	360011	01.2459
330395	01.1641	340050	01.1180	340121	01.0549	350015	01.4115	360012	01.1954
330396	01.0463	340051	01.1599	340122	01.1299	350016	01.0957	360013	01.0928
330397	01.2054	340052	00.9853	340123	01.1303	350017	01.1282	360014	01.1144
330398	01.0680	340053	01.3175	340124	00.9853	350018	01.0063	360015	01.3417
330399	01.1293	340054	00.9869	340125	01.2949	350019	01.2954	360016	01.2205
340001	01.1548	340055	01.1437	340126	01.1680	350020	01.1728	360017	01.2726
340002	01.4322	340060	01.1039	340127	01.1066	350021	01.0197	360018	01.1876
340003	01.0882	340061	01.4534	340129	01.0939	350023	01.0267	360019	01.1364
340004	01.2705	340063	01.1132	340130	01.1580	350024	00.9724	360020	01.1412
340005	01.2112	340064	01.0678	340131	01.2137	350025	00.9757	360021	01.1426
340006	01.1028	340065	01.0953	340132	01.1759	350027	00.9507	360022	01.0578
340007	01.1022	340067	01.0215	340133	00.9938	350029	00.9425	360024	01.0898
340008	01.0259	340068	01.1300	340135	00.9624	350030	01.0702	360025	01.0745
340009	00.8506	340069	01.5325	340136	00.9410	350031	00.9706	360026	01.1280
340010	01.2483	340070	01.2519	340137	01.0346	350032	01.1120	360027	01.3417
340011	01.0599	340071	01.0525	340138	01.0519	350033	00.9399	360028	01.1741
340012	01.1064	340072	01.0851	340141	01.2263	350034	00.9713	360029	01.0416
340013	01.1611	340073	01.1646	340142	01.1851	350035	00.8945	360030	01.0544
340014	01.2500	340075	01.1224	340143	01.2607	350036	00.9561	360031	01.1568
340015	01.1342	340076	01.0425	340144	01.1331	350038	00.9413	360032	01.1234
340016	01.1413	340079	00.9699	340145	01.1028	350039	00.9801	360034	01.0808
340017	01.1462	340080	01.0085	340146	01.0123	350041	00.9866	360035	01.3292
340018	01.2134	340084	01.0853	340147	01.1698	350042	00.9661	360036	01.0988
340019	01.0692	340085	01.2224	340148	01.1706	350043	01.1671	360037	01.4325
340020	01.1121	340087	01.0546	340151	01.0743	350044	00.9162	360038	01.2006
340021	01.1996	340088	01.1144	340153	01.8165	350047	00.9679	360039	01.1266
340022	01.1209	340089	01.0639	340154	00.9007	350048	00.9659	360040	01.1436
340023	01.0963	340090	01.1378	340155	01.3018	350049	01.0355	360041	01.1594
340024	01.1198	340091	01.5011	340156	00.9179	350050	00.9349	360042	01.0500
340025	01.1348	340093	01.0616	340157	01.2315	350051	00.9035	360044	01.1292
340026	00.9556	340094	01.1720	340158	01.0774	350053	00.9784	360045	01.2885
340027	01.1137	340096	01.1095	340159	01.0803	350055	00.8901	360046	01.0240
340028	01.1870	340097	01.0233	340160	01.0690	350056	00.9320	360047	01.0288
340030	01.5698	340098	01.4452	340162	01.1531	350058	00.9080	360048	01.3403
340031	01.0585	340099	01.1819	340164	01.1389	350060	01.0387	360049	01.1135
340032	01.2329	340100	01.1976	340166	01.1764	350061	01.0235	360050	01.1026
340034	01.2433	340101	01.1757	350001	00.8932	350063	00.8716	360051	01.2704
340035	01.0306	340104	00.9401	350002	01.3670	350064	00.9307	360052	01.2881
340036	01.0278	340105	01.2230	350003	01.0739	350065	01.0148	360053	01.1766
340037	01.1886	340106	01.0484	350004	01.4778	350066	00.8797	360054	01.1409
340038	01.1904	340107	01.1869	350005	01.1445	350067	00.9643	360055	01.1784
340039	01.1403	340109	01.2428	350006	01.0365	360001	01.1380	360056	01.1302
340040	01.4507	340111	01.1998	350007	00.9419	360002	01.1225	360057	01.0277
340041	01.1535	340112	01.0677	350008	00.9080	360003	01.2163	360058	01.0649
340042	01.1339	340113	01.7298	350009	01.1517	360006	01.4245	360059	01.2267
340044	01.0248	340114	01.1981	350010	01.0420	360007	01.0499	360060	01.0063
340045	01.0732	340115	01.2705	350011	01.4970	360008	01.1014	360061	00.9226
340047	01.5402	340116	01.4096	350012	00.9939	360009	01.1651	360062	01.2825

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360063	01.0512	360118	01.1858	360175	01.0838	370019	01.0234	370086	01.0784
360064	01.3148	360119	01.0807	360176	01.2109	370020	01.1454	370089	01.1137
360065	01.1635	360121	01.1335	360177	01.0559	370021	00.9840	370090	00.9977
360066	01.1287	360122	01.1417	360178	01.0894	370022	01.1522	370091	01.4349
360067	01.1015	360123	01.1168	360179	01.1539	370023	01.1141	370092	00.9947
360068	01.2557	360124	01.0997	360180	01.8374	370025	01.1993	370093	01.3854
360069	01.0311	360125	01.1005	360184	01.0552	370026	01.2400	370094	01.1543
360070	01.2064	360126	01.1270	360185	01.1329	370028	01.4518	370095	01.0433
360071	01.1536	360127	01.0117	360186	00.8953	370029	01.0514	370096	01.1559
360072	01.1370	360128	01.1077	360187	01.1491	370030	01.0657	370097	01.1446
360074	01.1805	360129	00.9890	360188	01.0434	370032	01.1540	370099	00.9751
360075	01.2070	360130	01.0725	360189	01.0243	370033	01.0079	370100	00.9766
360076	01.1535	360131	01.1143	360192	01.1797	370034	01.0767	370103	00.9964
360077	01.2339	360132	01.1030	360193	01.1325	370035	01.3222	370105	01.7711
360078	01.1136	360133	01.2503	360194	01.0620	370036	01.0309	370106	01.2215
360079	01.2914	360134	01.3202	360195	01.1236	370037	01.5325	370107	00.9905
360080	01.1183	360135	01.0732	360197	01.0381	370038	00.9676	370108	01.0008
360081	01.1021	360136	00.9882	360200	01.0893	370039	01.1383	370109	00.8723
360082	01.1916	360137	01.3648	360203	01.0872	370040	01.0733	370110	00.9618
360083	01.0772	360139	01.0585	360204	01.0814	370041	01.0201	370112	00.9622
360084	01.2505	360140	01.0574	360210	01.0839	370042	00.9049	370113	01.0215
360085	01.4497	360141	01.2550	360211	01.0667	370043	00.9437	370114	01.4322
360086	01.1387	360142	01.0219	360212	01.2146	370045	01.0443	370117	01.0821
360087	01.2264	360143	01.1531	360213	01.0994	370046	01.0102	370121	01.1654
360088	01.0570	360144	01.1846	360218	01.1380	370047	01.0908	370122	00.9063
360089	01.1170	360145	01.2976	360230	01.1876	370048	00.9706	370123	01.1306
360090	01.1240	360147	01.0836	360231	01.0699	370049	01.1218	370125	00.9454
360091	01.1867	360148	01.1188	360232	01.1749	370050	01.0167	370126	01.0585
360092	01.0668	360149	01.0519	360234	01.1560	370051	00.9664	370130	00.9570
360093	01.0526	360150	01.1892	360235	01.0793	370054	01.1221	370131	00.9772
360094	01.0868	360151	01.2348	360238	01.0334	370056	01.1807	370133	00.9893
360095	01.1525	360152	01.2306	360239	01.1223	370057	01.1728	370136	01.0192
360096	01.0756	360153	01.0948	360240	00.8073	370059	01.0652	370138	00.9942
360098	01.2232	360154	01.0418	360241	00.8241	370060	01.0699	370139	01.0215
360099	01.0699	360155	01.0869	360345	01.2490	370061	00.9832	370140	01.0167
360100	01.1626	360156	01.0748	370001	01.4762	370063	01.0652	370141	01.2256
360101	01.3497	360159	01.0896	370002	01.0058	370064	00.9326	370144	01.1892
360102	01.1957	360161	01.0911	370004	01.0543	370065	01.0727	370146	01.0125
360103	01.1806	360162	01.0879	370005	00.9421	370069	00.9923	370148	01.2066
360104	01.0672	360163	01.4270	370006	01.1208	370071	00.8988	370149	01.1653
360106	01.1667	360164	01.0085	370007	01.1513	370072	00.9325	370153	01.0477
360107	01.0755	360165	01.0471	370008	01.1704	370076	01.1284	370154	01.0031
360108	01.0660	360166	01.0035	370011	00.9630	370077	01.1316	370156	01.0122
360109	01.0273	360167	00.9055	370012	00.9615	370078	01.2983	370157	00.9912
360110	00.8157	360168	00.9856	370013	01.3594	370079	00.9275	370158	00.9980
360112	01.3308	360169	00.9714	370014	01.0443	370080	01.0337	370159	01.1611
360113	01.1609	360170	01.0514	370015	01.0924	370082	00.9824	370161	01.1035
360114	01.0142	360171	01.0517	370016	01.1374	370083	01.0124	370163	00.9234
360115	01.1259	360172	01.1444	370017	00.9887	370084	00.9328	370165	00.9627
360116	01.0740	360174	01.0609	370018	01.1347	370085	00.9670	370166	00.9870

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
370168	00.9277	380040	01.0291	390010	01.1083	390063	01.4444	390118	01.0319
370169	01.0457	380041	00.8411	390011	01.1370	390064	01.1520	390119	01.2067
370170	01.0620	380042	01.0846	390012	01.1698	390065	01.1644	390121	01.1284
370171	01.0288	380043	00.9998	390013	01.0962	390066	01.1661	390122	01.0669
370172	00.9470	380044	01.0206	390014	00.9227	390067	01.3474	390123	01.1505
370173	01.1466	380045	01.1054	390015	01.0692	390068	01.1267	390125	01.0954
370174	00.8946	380047	01.2703	390016	01.0621	390069	01.1650	390126	01.1565
370176	01.1213	380048	00.9334	390017	01.0340	390070	01.0823	390127	01.0681
370177	00.9907	380050	01.1552	390018	01.1377	390071	01.0810	390128	01.1136
370178	01.0256	380051	01.2431	390019	01.0681	390072	00.9923	390130	01.0476
370179	00.9947	380052	01.1289	390020	01.0976	390073	01.1277	390131	01.1481
370180	01.1293	380055	01.2138	390021	01.1246	390074	01.1771	390132	01.0768
370181	01.0142	380056	00.9802	390022	01.1068	390075	01.1732	390133	01.2306
370182	00.9843	380059	01.0233	390023	01.1039	390076	01.1567	390135	01.1182
370183	01.0243	380060	01.2597	390024	00.7299	390077	01.1273	390136	01.1042
370184	01.2777	380061	01.3778	390025	00.8091	390078	01.0353	390137	01.0847
380001	01.3291	380062	00.9253	390026	01.2369	390079	01.5655	390138	01.2305
380002	01.1481	380063	01.1435	390027	01.2972	390080	01.1541	390139	01.3462
380003	01.1867	380064	01.1420	390028	01.4328	390081	01.1991	390142	01.3625
380004	01.6210	380065	01.1364	390029	01.2939	390083	01.1093	390143	00.8680
380005	01.1580	380066	01.1953	390030	01.0301	390084	00.9841	390145	01.1046
380006	01.1148	380068	01.0555	390031	01.1198	390086	01.0555	390146	01.0952
380007	01.4401	380069	00.9755	390032	01.1294	390087	01.0344	390147	01.0938
380008	01.0788	380070	01.0161	390034	01.1170	390088	01.1988	390148	01.0816
380009	01.4170	380071	01.1450	390035	01.1525	390090	01.3625	390149	01.1170
380010	01.1776	380072	00.9579	390036	01.1589	390091	01.0635	390150	01.0759
380011	01.1091	380074	00.9667	390037	01.1400	390092	01.0422	390151	01.1543
380013	01.0997	380075	01.1784	390039	01.0230	390093	01.0862	390152	01.0777
380014	01.1385	380077	00.9469	390040	00.9909	390095	01.0993	390153	01.1619
380016	00.9029	380078	01.0525	390041	01.0965	390096	01.1848	390154	01.0783
380017	01.5029	380079	01.1847	390042	01.1185	390097	01.1968	390155	01.2183
380018	01.4547	380081	00.9773	390043	01.0013	390098	01.4141	390156	01.1649
380019	01.1014	380082	01.1604	390044	01.3935	390099	01.0855	390157	01.1147
380020	01.1882	380083	01.0726	390045	01.1967	390100	01.4378	390158	01.2277
380021	01.2351	380084	01.2673	390046	01.2856	390101	01.1813	390159	01.1642
380022	01.1229	380087	00.9313	390047	01.3739	390102	01.2148	390160	01.0542
380023	01.1002	380088	01.0196	390048	01.1218	390103	01.0488	390161	00.9983
380024	01.1431	380089	01.2296	390049	01.2513	390104	01.0309	390162	01.1706
380025	01.2607	380090	01.2488	390050	01.2109	390106	01.0406	390163	01.1328
380026	01.1402	380091	01.2271	390051	01.6394	390107	01.1189	390164	01.4538
380027	01.1218	380094	00.9518	390052	01.0756	390108	01.1631	390165	01.0555
380029	01.0500	390001	01.1792	390054	01.1129	390109	01.0244	390166	01.0895
380030	00.8741	390002	01.1649	390055	01.5176	390110	01.0896	390167	01.1231
380031	00.9599	390003	01.1186	390056	01.1071	390111	01.5178	390168	01.0813
380033	01.4012	390004	01.1528	390057	01.2506	390112	01.0952	390169	01.0970
380035	01.1918	390005	01.0133	390058	01.1824	390113	01.0984	390170	01.6197
380036	01.0710	390006	01.3776	390059	01.3006	390114	01.0252	390171	01.0403
380037	01.0891	390007	01.0979	390060	01.1272	390115	01.1798	390172	01.0667
380038	01.1311	390008	01.1020	390061	01.2194	390116	01.1063	390173	01.0898
380039	01.1918	390009	01.2642	390062	01.0976	390117	01.0237	390174	01.5334

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: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390176	01.1001	390244	00.9253	420023	01.1311	420084	00.7352	430060	00.9724
390177	00.9898	390245	01.1779	420024	00.9242	420085	01.1288	430062	00.8893
390178	01.1884	390246	01.0633	420026	01.5744	420086	01.1635	430064	01.0174
390179	01.1234	390247	01.0191	420027	01.1195	420087	01.2889	430065	00.9771
390180	01.2234	390249	01.0206	420028	00.9637	420088	01.1180	430066	00.9122
390181	01.0525	390252	01.0246	420029	01.9332	420089	01.0883	430072	01.0197
390183	01.0061	390256	01.5264	420030	01.0474	430001	01.1302	430073	01.0188
390184	01.0399	390258	01.1249	420031	00.9074	430004	01.0516	430076	00.9486
390185	01.1370	390260	01.1218	420032	00.9631	430005	01.0783	430077	01.1791
390186	01.0384	390261	01.6059	420033	01.1129	430007	01.0156	430079	01.0248
390187	01.0889	390262	01.2504	420035	00.7476	430008	01.1230	430080	00.9020
390188	01.0767	390263	01.2942	420036	01.1309	430009	01.0049	430081	00.9340
390189	01.0236	390265	01.1605	420037	01.0993	430010	01.0564	430082	00.9133
390191	01.0865	390266	01.1062	420038	01.0571	430011	01.1655	430083	00.8840
390192	01.0133	390267	01.0758	420039	01.0555	430012	01.2334	430084	00.8881
390193	01.1092	390268	01.1051	420040	01.1898	430013	01.1044	430085	00.9264
390194	00.9901	390270	01.1397	420042	01.0562	430014	01.1630	430086	01.0541
390195	01.3989	390272	00.9371	420043	01.0475	430015	01.0640	430087	00.8761
390197	01.1857	390275	01.0713	420044	01.0761	430016	01.2563	430088	00.9986
390198	01.0921	410001	01.1660	420048	01.0432	430017	01.0697	440001	01.0735
390199	01.1811	410002	01.1044	420049	00.9947	430018	00.9731	440002	01.3492
390200	01.0369	410004	01.1979	420050	00.9616	430020	01.0131	440003	01.1088
390201	01.1919	410005	01.2299	420051	01.2447	430022	00.8748	440005	00.9720
390203	01.1767	410006	01.1884	420053	00.9698	430023	01.0168	440006	01.1713
390204	01.1186	410007	01.3437	420054	01.0542	430024	00.9874	440007	01.0019
390205	01.1465	410008	01.1052	420055	00.9914	430025	00.9795	440008	00.9976
390206	01.1565	410009	01.1624	420056	01.0657	430026	00.9764	440009	01.0137
390209	00.9610	410010	00.9466	420057	01.0684	430027	01.4609	440010	01.0011
390211	01.0469	410011	01.1318	420059	01.0945	430028	00.9531	440011	01.1598
390213	00.9131	410012	01.3634	420061	01.0574	430029	00.9014	440012	01.1523
390215	01.1465	410013	01.1001	420062	01.0700	430030	01.0713	440014	01.0051
390217	01.0698	410014	01.1300	420064	01.0166	430031	00.8875	440015	01.4406
390219	01.1539	410016	01.0070	420065	01.1402	430033	01.0995	440016	00.9639
390220	01.0882	420002	01.1219	420066	00.9428	430034	01.0100	440017	01.2647
390222	01.1732	420003	01.0540	420067	01.0105	430036	01.0261	440018	01.1107
390223	01.5836	420004	01.3681	420068	01.1515	430037	00.8959	440019	01.3551
390224	00.8950	420005	01.0409	420069	01.0346	430038	01.0315	440020	00.9939
390225	01.1002	420006	01.1410	420070	01.1628	430039	00.9293	440022	01.0458
390226	01.3207	420007	01.2820	420071	01.1527	430040	01.0026	440023	00.9671
390228	01.1799	420009	01.1473	420072	00.9121	430041	01.0292	440024	01.1109
390229	01.2186	420010	01.0280	420073	01.1417	430042	01.0203	440025	01.0766
390231	01.2300	420011	01.0305	420074	00.9868	430043	01.0862	440026	01.1052
390232	01.0403	420014	01.0038	420075	00.9592	430044	00.9050	440028	01.0292
390233	01.2005	420015	01.1007	420076	00.8385	430047	00.9977	440029	01.1523
390234	01.1592	420016	01.0289	420078	01.2823	430048	01.0095	440030	01.0969
390235	01.5048	420017	00.9970	420079	01.2784	430049	00.9040	440031	00.9918
390236	01.0505	420018	01.3537	420080	01.0617	430051	01.0081	440032	01.0151
390237	01.3526	420019	01.0778	420081	00.7197	430054	00.9268	440033	01.0379
390238	00.7314	420020	01.0687	420082	01.1268	430056	00.9108	440034	01.1319
390242	01.1441	420022	01.0238	420083	01.0656	430057	00.8815	440035	01.1150

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TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
440038	01.0044	440113	01.0217	440183	01.2078	450045	01.0872	450111	01.0800
440039	01.3763	440114	01.0427	440184	01.1047	450046	01.2079	450112	01.1746
440040	00.9280	440115	01.0534	440185	01.0721	450047	01.0415	450113	01.1095
440041	00.9301	440117	00.8858	440186	01.0015	450048	01.0602	450115	01.0527
440046	01.0583	440120	01.1578	440187	01.0132	450050	01.0278	450116	01.2104
440047	00.9767	440121	01.0354	440189	01.1924	450051	01.5063	450118	01.1999
440048	01.3218	440125	01.1832	440191	00.9965	450052	01.1241	450119	01.1930
440049	01.3118	440128	00.8494	440192	01.0101	450053	01.0255	450121	01.2155
440050	01.0590	440130	01.0985	440193	01.0196	450054	01.4011	450122	00.9341
440051	00.9928	440131	01.0225	440194	01.0853	450055	01.0053	450123	01.1133
440052	00.9268	440132	01.0009	440196	01.0122	450056	01.3155	450124	01.3614
440053	01.1517	440133	01.2909	440197	01.1883	450057	01.1453	450126	01.2207
440054	00.9623	440134	01.0886	440200	00.9945	450058	01.2748	450127	01.0376
440055	01.0948	440135	01.0727	440202	00.9013	450059	01.1399	450128	01.1470
440056	00.9521	440136	01.0659	440203	01.0496	450060	01.1751	450130	01.2862
440057	00.9907	440137	01.0307	440204	01.1492	450063	00.9711	450131	01.1464
440058	01.0188	440141	00.9211	450002	01.1484	450064	01.3168	450132	01.2980
440059	01.0728	440142	00.8662	450004	01.0750	450065	01.0243	450133	01.1634
440060	01.0513	440143	00.9560	450005	00.9707	450066	01.3134	450134	01.0978
440061	01.1083	440144	01.0555	450007	01.1952	450068	01.2693	450135	01.3494
440063	01.0759	440145	00.9659	450008	01.1669	450069	00.9899	450136	00.9097
440064	00.9380	440146	00.9002	450010	01.1472	450070	01.0891	450137	01.1833
440065	01.0401	440147	00.7400	450011	01.2067	450072	01.1333	450140	00.8459
440067	01.0280	440148	01.0761	450013	01.2134	450073	01.0563	450141	00.9185
440068	01.1203	440149	01.0049	450014	01.0124	450074	01.0621	450142	01.1091
440069	01.1295	440150	01.1672	450015	01.3032	450077	01.0246	450143	01.0372
440070	00.9686	440151	01.0660	450016	01.3191	450078	00.9832	450144	01.0328
440071	01.1288	440152	01.2740	450018	01.3197	450079	01.1618	450145	01.0060
440072	01.1192	440153	00.9194	450019	01.2142	450080	01.1544	450146	00.8904
440073	01.1377	440154	00.9511	450020	01.0646	450081	01.1651	450147	01.1459
440074	00.9324	440156	01.1975	450021	01.4963	450082	00.9547	450148	01.1499
440078	00.9512	440157	00.9092	450022	01.0288	450083	01.2507	450149	01.1844
440079	00.8861	440159	01.0905	450023	01.3048	450084	01.0720	450150	01.0662
440081	01.0915	440160	00.9624	450024	01.1622	450085	01.0735	450151	01.0298
440082	01.6461	440161	01.4350	450025	01.2916	450087	01.2083	450152	01.1739
440083	00.9430	440162	00.9944	450027	01.1027	450090	01.1306	450153	01.2805
440084	01.0386	440166	01.1661	450028	01.2221	450092	01.0552	450154	01.1359
440087	00.9046	440167	01.1789	450029	01.1202	450094	01.0820	450155	01.0576
440090	01.0643	440168	01.0337	450031	01.1884	450095	01.1029	450157	01.0449
440091	01.2935	440170	00.7345	450032	01.1480	450096	01.3257	450160	00.8966
440095	00.9807	440171	01.0382	450033	01.4080	450097	01.2027	450162	01.2240
440100	00.9789	440173	01.1112	450034	01.3737	450098	01.0342	450163	01.0311
440101	00.8896	440174	00.9321	450035	01.2145	450099	01.0784	450164	00.9733
440102	01.0569	440175	01.0055	450037	01.2098	450101	01.2081	450165	01.0095
440103	01.0429	440176	01.1232	450039	01.1412	450102	01.3946	450166	00.9717
440104	01.2659	440177	00.9653	450040	01.3394	450104	01.0762	450169	00.8962
440105	00.6471	440178	01.1264	450041	00.9906	450107	01.2134	450170	01.0874
440109	01.0718	440180	00.9969	450042	01.4546	450108	00.9763	450174	01.1422
440110	01.0431	440181	01.0377	450043	01.1777	450109	01.0626	450175	01.0982
440111	01.1323	440182	00.9309	450044	01.4634	450110	01.1513	450176	01.1414

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450177	01.0493	450250	00.8346	450333	01.0758	450421	01.0628	450544	01.1130
450178	00.9505	450253	01.0518	450334	01.0458	450422	00.6607	450545	01.2230
450179	01.1225	450256	00.9440	450337	01.0211	450423	01.2546	450546	01.1392
450181	00.9472	450258	00.8589	450338	01.2968	450424	01.1372	450547	00.9417
450182	00.9065	450259	01.1117	450340	01.1616	450425	00.9850	450550	01.1007
450183	01.0993	450260	01.0296	450341	00.9312	450429	01.0360	450551	01.0085
450184	01.3163	450261	01.0463	450342	00.9696	450431	01.3091	450557	00.9848
450185	00.9496	450263	01.1240	450343	01.0316	450438	01.0700	450558	01.3752
450187	01.2378	450264	00.8902	450346	01.1765	450440	00.9595	450559	00.9492
450188	00.9501	450268	01.0319	450347	01.0996	450446	00.9566	450561	01.2929
450190	01.1410	450269	00.9770	450348	01.0489	450447	01.1840	450563	01.1279
450191	01.1713	450270	01.0022	450349	01.0993	450450	01.0495	450565	01.1495
450192	01.0865	450271	01.1133	450351	01.1099	450451	00.9430	450568	01.1294
450193	02.0078	450272	01.1495	450352	01.1591	450454	00.9789	450569	01.1287
450194	01.0571	450275	01.0470	450353	01.0851	450455	00.9406	450570	00.9553
450195	01.1980	450276	00.9994	450355	00.9291	450457	01.3304	450571	01.2031
450196	01.2005	450278	00.9179	450357	01.0505	450458	00.9320	450573	01.1038
450197	01.1217	450280	01.2045	450358	01.5600	450459	01.0279	450574	00.9663
450200	01.1709	450281	01.2081	450359	00.8630	450460	00.9415	450575	01.0680
450201	01.0867	450282	00.9368	450362	01.0158	450462	01.2914	450577	00.9004
450203	01.1424	450283	00.9730	450365	01.0667	450464	00.9812	450578	00.9395
450206	01.0389	450286	01.1495	450366	01.1527	450465	01.0734	450579	00.8658
450207	01.1943	450288	01.0841	450369	01.0575	450467	01.0085	450580	01.0987
450208	01.2200	450289	01.0750	450370	01.1096	450469	01.2082	450581	01.0923
450209	01.1933	450292	01.1101	450371	01.0142	450472	01.0129	450583	00.9596
450210	01.0507	450293	00.9602	450372	01.2665	450473	01.0361	450584	01.0799
450211	01.1122	450296	01.0009	450373	01.1326	450475	01.0730	450586	01.0461
450213	01.2284	450297	01.0202	450374	00.8975	450476	00.9235	450587	01.0815
450214	01.0949	450299	01.1338	450376	01.2494	450481	01.0235	450588	00.9549
450217	01.0155	450300	00.9542	450378	01.2035	450484	01.1332	450590	00.8933
450218	01.0132	450303	00.9897	450379	01.1483	450486	01.0739	450591	01.1604
450219	01.0701	450305	00.8276	450381	01.0431	450488	01.0542	450595	01.0587
450221	00.9798	450306	00.9942	450382	00.9534	450489	01.0341	450596	01.0936
450222	01.1617	450307	00.9587	450388	01.3044	450492	00.9533	450597	01.0391
450224	01.0874	450309	01.0754	450389	01.1261	450493	00.9685	450600	01.0487
450229	01.1922	450311	00.8916	450391	01.1224	450497	01.1001	450603	00.8003
450230	01.1730	450312	01.1707	450393	01.1803	450498	00.9859	450604	01.1212
450231	01.3805	450315	01.1721	450394	01.1447	450508	01.1966	450605	01.1770
450233	00.9712	450317	01.0033	450395	01.0096	450513	00.9685	450607	00.9306
450234	00.9177	450319	01.0756	450399	00.9878	450514	01.1085	450609	00.9807
450235	01.0664	450320	01.2463	450400	01.0497	450517	00.9353	450610	01.2166
450236	01.0389	450321	00.8689	450402	01.1649	450518	01.1183	450613	00.9882
450237	01.2290	450322	00.8951	450403	01.2770	450523	01.2306	450614	01.0470
450239	01.0878	450324	01.2385	450410	01.0240	450527	01.0729	450615	00.9589
450241	01.0321	450325	01.0781	450411	00.9795	450530	01.2085	450617	01.1779
450242	01.0622	450327	00.9670	450415	01.1009	450534	00.8927	450620	01.0332
450243	00.9757	450328	00.9721	450416	01.1563	450535	01.0850	450621	00.9928
450246	00.9765	450330	01.0920	450417	00.9151	450537	01.1933	450623	01.0245
450248	01.0588	450331	00.9976	450418	01.2526	450538	01.1620	450624	01.0275
450249	00.9732	450332	01.0575	450419	01.0455	450539	01.1936	450626	01.0305

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450627	01.1284	450687	01.0573	460012	01.4429	490006	01.0945	490071	01.2113
450628	00.9403	450688	01.1059	460013	01.2727	490007	01.5307	490073	01.1364
450629	00.8633	450690	01.2237	460014	01.0705	490008	01.0353	490074	01.2412
450630	01.3904	450691	01.0873	460015	01.1125	490009	01.4036	490075	01.1553
450631	01.4954	450694	01.0588	460016	00.9015	490010	01.0345	490077	01.1282
450632	01.0314	450696	01.0777	460017	01.2001	490011	01.1686	490078	00.9457
450633	01.4003	450697	01.1667	460018	00.9417	490012	01.0049	490079	01.1057
450634	01.2350	450698	00.9027	460019	00.9864	490013	01.0679	490083	00.7770
450635	01.2345	450700	01.0038	460020	01.0446	490014	01.3850	490084	01.0315
450637	01.1298	450702	01.1659	460021	01.1994	490015	01.1757	490085	01.0359
450638	01.3189	450703	01.0667	460022	00.9910	490017	01.2271	490088	01.0625
450639	01.2020	450704	01.1661	460023	01.0839	490018	01.0987	490089	01.0198
450641	00.9530	450705	00.9181	460024	01.0167	490019	01.0888	490090	01.0748
450643	01.0778	450706	01.2111	460025	00.9384	490020	01.0660	490091	01.1707
450644	01.6145	450709	01.0539	460026	00.9009	490021	01.1158	490092	01.0805
450646	01.1772	450711	01.1778	460027	00.8630	490022	01.1096	490093	01.1736
450647	01.5706	450712	00.9614	460029	01.0076	490023	01.1553	490094	01.1745
450648	01.1037	450713	01.1565	460030	01.0574	490024	01.3789	490095	01.1582
450649	01.0275	450715	01.2140	460032	00.9334	490027	01.0104	490097	01.0629
450651	01.1563	450716	01.0902	460033	00.8984	490028	01.1522	490098	01.0826
450652	00.9619	450717	01.2083	460035	00.9753	490029	01.1020	490099	01.0734
450653	01.1188	450718	01.0159	460036	01.0085	490030	01.0776	490100	01.1835
450654	00.9870	450719	01.0875	460037	00.9775	490031	01.0442	490101	01.0789
450656	01.1512	450722	00.9833	460039	00.9054	490032	01.5967	490104	00.7406
450658	01.0194	450723	01.2009	460041	01.1658	490033	01.1126	490105	00.9531
450659	01.3214	450724	01.2951	460042	01.2567	490035	01.1380	490106	00.9741
450660	01.3082	450725	00.9471	460043	01.1733	490037	01.1049	490107	01.0270
450661	01.0815	450726	00.9112	460044	01.0925	490038	01.0493	490109	01.0077
450662	01.1772	450727	01.1250	460046	01.0487	490040	01.1720	490110	01.0614
450665	00.9977	450728	01.0602	470001	01.1101	490041	01.1095	490111	01.0483
450666	01.1193	450729	01.0147	470003	01.5509	490042	01.1131	490112	01.4265
450667	00.9643	450730	01.1851	470004	01.1027	490043	01.1353	490113	01.1141
450668	01.4044	450732	01.0615	470005	01.1491	490044	01.1028	490114	01.0375
450669	01.1601	450733	01.1389	470006	01.1437	490045	01.1430	490115	01.0531
450670	01.0938	450734	01.0484	470008	01.1182	490046	01.2359	490116	00.9766
450671	00.9149	450735	00.8897	470010	01.0860	490047	01.1054	490117	00.9875
450672	01.3346	450736	01.0380	470011	01.1684	490048	01.1638	490118	01.4251
450673	01.1021	450737	00.8896	470012	01.1441	490050	01.1409	490119	01.1607
450674	00.9972	450738	00.8868	470013	01.0474	490052	01.2965	490120	01.1862
450675	01.1305	450739	00.9744	470015	01.1531	490053	01.1295	490122	01.0837
450676	01.0100	460001	01.4576	470016	01.0610	490054	00.9699	490123	01.0992
450677	01.2071	460003	01.3346	470018	01.0717	490055	00.8837	490124	01.1422
450678	01.2324	460004	01.3952	470020	00.9893	490056	00.8551	490125	01.1589
450679	01.0040	460005	01.1782	470023	01.1876	490057	01.1668	490126	01.0688
450681	01.2207	460006	01.1915	470024	01.1028	490059	01.2320	490127	00.8987
450682	01.1303	460007	01.1633	490001	00.9369	490060	00.9246	490129	01.0293
450683	01.2162	460008	01.1533	490002	00.9635	490063	01.3702	490130	01.1391
450684	01.1589	460009	01.4268	490003	00.6806	490066	01.0888	500001	01.2747
450685	01.1280	460010	01.6331	490004	01.1593	490067	01.1131	500002	01.2508
450686	01.2720	460011	01.0841	490005	01.2525	490069	01.2028	500003	01.2047

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TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
500005	01.4045	500064	01.3408	510001	01.2302	510064	01.0944	520037	01.4914
500007	01.2217	500065	01.1476	510002	01.1185	510065	01.0330	520038	01.1142
500008	01.8330	500066	00.8008	510003	01.0607	510066	01.0442	520039	01.0725
500009	01.2418	500068	00.9925	510004	00.9484	510067	01.1483	520040	01.2437
500010	01.1628	500069	01.0205	510005	01.0601	510068	01.1120	520041	01.1258
500011	01.1978	500070	01.0770	510006	01.1352	510070	01.0426	520042	01.0527
500012	01.3458	500071	01.0825	510007	01.2792	510071	01.1544	520043	01.4567
500014	01.5000	500072	01.1477	510008	01.0842	510072	01.0619	520044	01.1884
500015	01.2320	500073	00.9982	510009	01.1172	510074	00.9496	520045	01.4066
500016	01.3219	500074	01.0476	510011	00.9832	510076	00.9701	520047	00.9868
500017	01.2102	500075	01.1087	510012	01.0370	510077	00.9619	520048	01.2470
500019	01.1229	500076	01.1168	510013	01.0657	510080	00.9585	520049	01.7147
500020	01.2303	500077	01.2237	510014	01.1125	510081	00.9940	520051	01.5837
500021	01.2297	500078	01.1972	510015	00.9892	510082	00.9629	520053	01.0558
500023	01.1361	500079	01.1502	510016	00.9477	510084	01.0139	520054	01.0942
500024	01.2790	500080	00.9879	510018	01.0691	510085	01.1446	520056	01.1195
500025	01.7745	500084	01.0567	510019	00.9997	510086	00.9165	520057	01.1199
500026	01.1935	500085	01.0156	510020	01.0951	520001	01.2060	520058	01.0733
500027	01.4141	500086	01.1563	510022	01.3897	520002	01.2006	520059	01.1633
500028	00.9896	500087	01.2309	510023	01.0255	520003	01.1356	520060	01.1450
500029	01.0069	500088	01.2342	510024	01.1903	520004	01.2492	520062	01.1591
500030	01.3444	500089	01.0934	510025	01.0109	520006	01.1054	520063	01.1892
500031	01.1510	500090	00.8993	510026	00.9906	520007	01.1028	520064	01.4500
500033	01.2064	500092	01.0778	510027	01.0608	520008	01.1730	520066	01.1650
500034	01.0650	500093	01.0854	510028	01.0340	520009	01.2435	520068	01.0254
500035	01.2450	500094	01.0688	510029	01.0798	520010	01.0300	520069	01.1486
500036	01.1831	500096	01.0840	510030	01.1370	520011	01.1090	520070	01.2401
500037	01.0634	500097	01.0945	510031	01.0963	520012	01.0378	520071	01.1302
500039	01.1721	500098	00.9487	510033	01.1697	520013	01.1925	520074	01.1094
500040	01.0597	500100	00.9570	510035	00.9676	520014	01.1499	520075	01.2633
500041	01.2474	500101	01.0250	510036	01.1259	520015	01.1903	520076	01.1789
500042	01.1794	500102	01.0006	510038	01.0315	520016	01.0267	520077	00.9974
500043	01.1312	500104	01.1327	510039	01.1301	520017	01.0956	520078	01.2116
500044	01.6493	500106	00.9360	510040	00.9391	520018	01.0649	520081	01.1505
500045	01.1298	500107	01.1029	510043	01.0109	520019	01.1722	520082	01.1524
500046	01.2376	500108	01.4962	510045	00.8964	520020	01.3604	520083	01.4012
500048	00.9234	500109	01.1873	510046	01.1469	520021	01.1677	520084	01.0651
500049	01.2088	500110	01.1821	510047	01.1562	520022	01.1814	520087	01.4261
500050	01.0925	500114	01.2774	510048	01.0718	520024	01.0071	520088	01.2093
500051	01.3487	500118	01.1567	510050	01.1270	520025	01.0781	520089	01.2551
500052	01.0782	500119	01.2255	510052	01.0619	520026	01.1672	520090	01.0803
500053	01.1165	500122	01.2382	510053	00.9889	520027	01.1448	520091	01.2744
500054	01.6139	500123	00.9212	510054	00.9677	520028	01.2454	520092	01.1239
500055	01.0151	500124	01.1815	510055	01.1684	520029	01.0132	520094	01.2751
500057	01.1927	500125	01.0527	510058	01.1631	520030	01.3105	520095	01.1375
500058	01.2348	500129	01.4396	510059	00.6434	520031	01.1753	520096	01.2207
500059	01.1272	500132	00.9319	510060	01.0282	520032	01.1877	520097	01.1472
500060	01.1088	500133	01.1760	510061	01.0246	520033	01.2546	520098	01.4752
500061	00.9885	500135	01.1356	510062	01.1437	520034	01.1730	520100	01.1173
500062	00.9942	500139	01.1202	510063	01.1007	520035	01.1291	520101	01.0387

NOTE: CASE MIX INDEXES DO NOT INCLUDE DISCHARGES FROM PPS-EXEMPT UNITS.
: CASE MIX INDEXES INCLUDE CASES RECEIVED IN HCFA CENTRAL OFFICE THROUGH FEB., 1987.

TABLE 3C HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1986

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
520102	01.1066	520171	01.0028						
520103	01.1966	520173	01.0988						
520104	00.9739	520174	01.3942						
520105	01.0375	520175	00.8055						
520107	01.1555	520177	01.3209						
520109	01.0358	520178	01.1982						
520110	01.0781	520183	00.9413						
520111	01.0568	530001	01.0948						
520112	01.0538	530002	01.0857						
520113	01.1505	530003	00.9316						
520114	01.0737	530004	01.0044						
520115	01.1978	530005	00.9924						
520116	01.1347	530006	01.0808						
520117	01.0408	530007	01.2185						
520118	00.9915	530008	01.0301						
520120	01.1975	530009	00.9941						
520121	00.9771	530010	01.1473						
520122	01.0741	530011	01.0896						
520123	01.1155	530012	01.3296						
520124	01.0938	530014	01.1217						
520126	00.9720	530015	01.1142						
520127	00.9992	530016	01.1626						
520130	00.9509	530017	00.8838						
520131	01.0235	530018	00.9973						
520132	01.1441	530019	00.9290						
520134	01.0482	530021	00.8815						
520135	01.0149	530022	00.9898						
520136	01.3536	530023	00.9146						
520138	01.6703	530024	01.0007						
520139	01.2157	530025	01.0953						
520140	01.2635	530026	01.0241						
520141	01.0750	530027	00.9723						
520142	01.0683	530029	01.0512						
520143	01.0489	530031	00.8946						
520144	01.0180	530032	01.0306						
520145	01.0535								
520146	01.0772								
520148	01.1108								
520149	01.1158								
520151	01.0289								
520152	01.0912								
520153	01.0166								
520154	01.1156								
520156	01.0029								
520157	01.0373								
520159	01.0239								
520160	01.6673								
520161	00.9957								
520167	01.1911								
520170	01.1325								

BILLING CODE 4120-01-C

Urban area (constituent counties or county equivalents)	Wage index
Amarillo, TX	0.9326
Potter, TX	
Randall, TX	
Anaheim-Santa Ana, CA	1.2031
Orange, CA	
Anchorage, AK	1.4619
Anchorage, AK	
Anderson, IN	0.9175
Madison, IN	
Anderson, SC	0.7839
Anderson, SC	
Ann Arbor, MI	1.1723
Washtenaw, MI	
Anniston, AL	0.7847
Calhoun, AL	
Appleton-Oshkosh-Neenah, WI	0.9792
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
Arecibo, PR	0.4401
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
Quebradillas, PR	
Asheville, NC	0.8501
Buncombe, NC	
Athens, GA	0.7710
Clarke, GA	
Jackson, GA	
Madison, GA	
Oconee, GA	
Atlanta, GA	0.9196
Barrow, GA	
Butts, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
Atlantic City, NJ	0.9898
Atlantic, NJ	
Cape May, NJ	
Augusta, GA-SC	0.8908
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Aurora-Elgin, IL	1.0123
Kane, IL	
Kendall, IL	
Austin, TX	1.0409
Hays, TX	
Travis, TX	
Williamson, TX	
Bakersfield, CA	1.1792
Kern, CA	
Baltimore, MD	1.0181
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
Bangor, ME	0.8907
Penobscot, ME	
Baton Rouge, LA	0.8665
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
Battle Creek, MI	0.9670
Calhoun, MI	
Beaumont-Port Arthur, TX	0.9394
Hardin, TX	
Jefferson, TX	
Orange, TX	
Beaver County, PA	1.0368
Beaver, PA	
Bellingham, WA	1.0823
Whatcom, WA	
Benton Harbor, MI	0.8436
Berrien, MI	
Bergen-Passaic, NJ	1.0299
Bergen, NJ	
Passaic, NJ	
Billings, MT	0.9756
Yellowstone, MT	
Biloxi-Gulfport, MS	0.8012
Hancock, MS	
Harrison, MS	
Binghamton, NY	0.9107
Broome, NY	
Tioga, NY	
Birmingham, AL	0.9226
Blount, AL	
Jefferson, AL	
Saint Clair, AL	
Shelby, AL	
Walker, AL	
Bismarck, ND	0.9315
Burleigh, ND	
Morton, ND	
Bloomington, IN	0.9215
Monroe, IN	
Bloomington-Normal, IL	0.9463
McLean, IL	
Boise City, ID	0.9821
Ada, ID	
Boston-Lawrence-Salem-Lowell-Brockton, MA	1.0825
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Boulder-Longmont, CO	1.0717
Boulder, CO	
Bradenton, FL	0.8796
Manatee, FL	
Brazoria, TX	0.8333
Brazoria, TX	
Bremerton, WA	0.9407
Kitsap, WA	
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1230
Fairfield, CT	
Brownsville-Harlingen, TX	0.8538
Cameron, TX	
Bryan-College Station, TX	0.9377
Brazos, TX	
Buffalo, NY	0.9726
Erie, NY	
Burlington, NC	0.7548
Alamance, NC	
Burlington, VT	0.9464
Chittenden, VT	
Grand Isle, VT	
Caguas, PR	0.3984
Caguas, PR	
Gurabo, PR	
San Lorenz, PR	
Aguas Buenas, PR	
Cayey, PR	
Cidra, PR	
Canton, OH	0.9195
Carroll, OH	
Stark, OH	
Casper, WY	0.9842
Natrona, WY	
Cedar Rapids, IA	0.9242
Linn, IA	
Champaign-Urbana-Rantoul, IL	0.9141
Champaign, IL	
Charleston, SC	0.8467
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
Charleston, WV	0.9757
Kanawha, WV	
Putnam, WV	
Charlotte-Gastonia-Rock Hill, NC-SC	0.8424
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
Charlottesville, VA	0.8822
Albermarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
Chattanooga, TN-GA	0.9165
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
Sequatchie, TN	
Cheyenne, WY	0.8959
Laramie, WY	
Chicago, IL	1.1211
Cook, IL	
Du Page, IL	
McHenry, IL	
Chico, CA	1.1145
Butte, CA	
Cincinnati, OH-KY-IN	1.0319
Dearborn, IN	
Boone, KY	
Campbell, KY	
Kenton, KY	
Clermont, OH	
Hamilton, OH	
Warren, OH	
Clarksville-Hopkinsville, TN-KY	0.7485

Urban area (constituent counties or county equivalents)	Wage index
Christian, KY	
Montgomery, TN	
Cleveland, OH	1.0826
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Medina, OH	
Colorado Springs, CO	1.0047
El Paso, CO	
Columbia, MO	1.0378
Boone, MO	
Columbia, SC	0.8450
Lexington, SC	
Richland, SC	
Columbus, GA-AL	0.7406
Russell, AL	
Chattanoochee, GA	
Muscogee, GA	
Columbus, OH	0.9296
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
Union, OH	
Corpus Christi, TX	0.8801
Nueces, TX	
San Patricio, TX	
Cumberland, MD-WV	0.8798
Allegeny, MD	
Mineral, WV	
Dallas, TX	0.9565
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Kaufman, TX	
Rockwall, TX	
Danville, VA	0.7621
Danville City, VA	
Pittsylvania, VA	
Davenport-Rock Island-Moline, IA-IL	0.9739
Scott, IA	
Henry, IL	
Rock Island, IL	
Dayton-Springfield, OH	1.0107
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
Daytona Beach, FL	0.8545
Volusia, FL	
Decatur, IL	0.8966
Macon, IL	
Denver, CO	1.1934
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
Des Moines, IA	0.9824
Dallas, IA	
Polk, IA	
Warren, IA	
Detroit, MI	1.0911
Lapeer, MI	
Livingston, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
Saint Clair, MI	
Wayne, MI	
Dothan, AL	0.7892
Dale, AL	
Houston, AL	
Dubuque, IA	0.9712
Dubuque, IA	
Duluth, MN-WI	0.9477
St. Louis, MN	
Douglas, WI	
Eau Claire, WI	0.8903
Chippewa, WI	
Eau Claire, WI	
El Paso, TX	0.8849
El Paso, TX	
Elkhart-Goshen, IN	0.9142
Elkhart, IN	
Elmira, NY	0.9152
Chemung, NY	
Enid, OK	0.9125
Garfield, OK	
Erie, PA	0.9488
Erie, PA	
Eugene-Springfield, OR	1.0353
Lane, OR	
Evansville, IN KY	0.9963
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
Fargo-Moorhead, ND-MN	1.0031
Clay, MN	
Cass, ND	
Fayetteville, NC	0.7983
Cumberland, NC	
Fayetteville-Springdale, AR	0.7494
Washington, AR	
Flint, MI	1.1458
Genesee, MI	
Shiawassee, MI	
Florence, AL	0.7255
Colbert, AL	
Lauderdale, AL	
Florence, SC	0.7472
Florence, SC	
Fort Collins-Loveland, CO	1.0252
Larimor, CO	
Fort Lauderdale-Hollywood-Pompano Beach, FL	1.0424
Broward, FL	
Fort Myers-Cape Coral, FL	0.8989
Lee, FL	
Fort Pierce, FL	1.0052
Martin, FL	
St. Lucie, FL	
Fort Smith, AR OK	0.8726
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
Fort Walton Beach, FL	0.8210
Okaloosa, FL	
Fort Wayne, IN	0.9008
Allen, IN	
De Kalb, IN	
Whitley, IN	
Fort Worth-Arlington, TX	0.9475
Johnson, TX	
Parker, TX	
Tarrant, TX	
Fresno, CA	1.0978
Fresno, CA	
Gadsden, AL	0.8394
Etowah, AL	
Gainesville, FL	0.8902
Alachua, FL	
Bradford, FL	
Galveston-Texas City, TX	1.0782
Galveston, TX	
Gary-Hammond, IN	1.0415
Lake, IN	
Porter, IN	
Glens Falls, NY	0.8889
Warren, NY	
Washington, NY	
Grand Forks, ND	0.9462
Grand Forks, ND	
Grand Rapids, MI	1.0058
Kent, MI	
Ottawa, MI	
Great Falls, MT	0.9966
Cascade, MT	
Greeley, CO	1.0174
Weld, CO	
Green Bay, WI	0.9692
Brown, WI	
Greensboro-Winston-Salem-High Point, NC	0.8710
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
Greenville-Spartanburg, SC	0.8961
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
Hagerstown, MD	0.8869
Washington, MD	
Hamilton-Middletown, OH	0.9649
Butler, OH	
Harrisburg-Lebanon-Carlisle, PA	0.9907
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
Hartford-Middletown-New Britain-Bristol, CT	1.0898
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
Hickory, NC	0.8335
Alexander, NC	
Burke, NC	
Catawba, NC	
Honolulu, HI	1.1343
Honolulu, HI	
Houma-Thibodaux, LA	0.8083
Lafourche, LA	
Terrebonne, LA	
Houston, TX	0.9868

Urban area (constituent counties or county equivalents)	Wage index
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
Huntington-Ashland, WV-KY-OH	0.9066
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
Huntsville, AL	0.8208
Madison, AL	
Indianapolis, IN	0.9941
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
Iowa City, IA	1.1630
Johnson, IA	
Jackson, MI	0.9445
Jackson, MI	
Jackson, MS	0.8439
Hinds, MS	
Madison, MS	
Rankin, MS	
Jackson, TN	0.7506
Madison, TN	
Jacksonville, FL	0.8923
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
Jacksonville, NC	0.7358
Onslow, NC	
Janesville-Beloit, WI	0.8935
Rock, WI	
Jersey City, NJ	1.0599
Hudson, NJ	
Johnson City-Kingsport-Bristol, TN-VA	0.8446
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
Johnstown, PA	0.9060
Cambria, PA	
Somerset, PA	
Joliet, IL	1.0507
Grundy, IL	
Will, IL	
Joplin, MO	0.8649
Jasper, MO	
Newton, MO	
Kalamazoo, MI	1.1352
Kalamazoo, MI	
Kankakee, IL	0.8989
Kankakee, IL	
Kansas City, KS-MO	1.0064
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
Kenosha, WI	1.0384
Kenosha, WI	
Killeen-Temple, TX	0.9789
Bell, TX	
Coryell, TX	
Knoxville, TN	0.8335
Anderson, TN	
Blount, TN	
Grainger, TN	
Jefferson, TN	
Knox, TN	
Sevier, TN	
Union, TN	
Kokomo, IN	0.9352
Howard, IN	
Tipton, IN	
LaCrosse, WI	0.9629
LaCrosse, WI	
Lafayette, LA	0.9261
Lafayette, LA	
St. Martin, LA	
Lafayette, IN	0.8736
Tippecanoe, IN	
Lake Charles, LA	0.9172
Calcasieu, LA	
Lake County, IL	1.0904
Lake, IL	
Lakeland-Winter Haven, FL	0.8261
Polk, FL	
Lancaster, PA	0.9866
Lancaster, PA	
Lansing-East Lansing, MI	1.0251
Clinton, MI	
Eaton, MI	
Ingham, MI	
Laredo, TX	0.7521
Webb, TX	
Las Cruces, NM	0.8362
Dona Ana, NM	
Las Vegas, NV	1.0873
Clark, NV	
Lawrence, KS	0.9748
Douglas, KS	
Lawton, OK	0.8579
Comanche, OK	
Lewiston-Auburn, ME	0.9034
Androscoggin, ME	
Lexington-Fayette, KY	0.9227
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Scott, KY	
Woodford, KY	
Lima, OH	0.9233
Allen, OH	
Auglaize, OH	
Lincoln, NE	0.9287
Lancaster, NE	
Little Rock-North Little Rock, AR	0.9376
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
Longview-Marshall, TX	0.8037
Gregg, Tx	
Harrison, TX	
Lorain-Elyria, OH	0.9519
Lorain, OH	
Los Angeles-Long Beach, CA	1.2431
Los Angeles, CA	
Louisville, KY-IN	0.9520
Clark, IN	
Floyd, IN	
Harrison, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
Shelby, KY	
Lubbock, TX	0.9568
Lubbock, TX	
Lynchburg, VA	0.8586
Amherst, VA	
Campbell, VA	
Lynchburg City, VA	
Macon-Warner Robins, GA	0.8275
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Madison, WI	1.0167
Dane, WI	
Manchester-Nashua, NH	0.9222
Hillsborough, NH	
Merrimack, NH	
Mansfield, OH	0.9116
Richland, OH	
Mayaguez, PR	0.4842
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
San German, PR	
McAllen-Edinburg-Mission, TX	0.7655
Hidalgo, TX	
Medford, OR	0.9701
Jackson, OR	
Melbourne-Titusville, FL	0.8862
Brevard, FL	
Memphis, TN-AR-MS	0.9644
Crittenden, AR	
De Soto, MS	
Shelby, TN	
Tipton, TN	
Merced, CA	1.0727
Merced, CA	
Miami-Hialeah, FL	1.0151
Dade, FL	
Middlesex-Somerset-Hunterdon, NJ	0.9837
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
Midland, TX	1.0576
Midland, TX	
Milwaukee, WI	1.0435
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
Minneapolis St. Paul, MN-WI	1.1224

Urban area (constituent counties or county equivalents)	Wage index
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Washington, MN	
Wright, MN	
St. Croix, WI	
Mobile, AL	0.8319
Baldwin, AL	
Mobile, AL	
Modesto, CA	1.1049
Stanislaus, CA	
Monmouth-Ocean, NJ	0.9365
Monmouth, NJ	
Ocean, NJ	
Monroe, LA	0.8471
Ouachita, LA	
Montgomery, AL	0.8173
Autauga, AL	
Elmore, AL	
Montgomery, AL	
New York, NY	1.3092
Bronx, NY	
Kings, NY	
New York City, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
Newark, NJ	1.0808
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Niagara Falls, NY	0.8492
Niagara, NY	
Norfolk-Virginia Beach-Newport News, VA	0.9196
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
James City Co., VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	
Oakland, CA	1.4023
Alameda, CA	
Contra Costa, CA	
Ocala, FL	0.8183
Marion, FL	
Odessa, TX	0.8919
Ector, TX	
Oklahoma City, OK	1.0065
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
Olympia, WA	1.0349
Thurston, WA	
Omaha, NE-IA	0.9822
Pottawattamie, IA	
Douglas, NE	
Sarpy, NE	
Washington, NE	
Orange County, NY	0.8828
Orange, NY	
Orlando, FL	0.9356
Orange, FL	
Osceola, FL	
Seminole, FL	
Owensboro, KY	0.8360
Daviess, KY	
Oxnard-Ventura, CA	1.2976
Ventura, CA	
Panama City, FL	0.7882
Bay, FL	
Parkersburg-Marietta, WV-OH	0.8828
Washington, OH	
Wood, WV	
Pascagoula, MS	0.8929
Jackson, MS	
Pensacola, FL	0.8241
Escambia, FL	
Santa Rosa, FL	
Peoria, IL	0.9879
Peoria, IL	
Tazewell, IL	
Woodford, IL	
Philadelphia, PA-NJ	1.0935
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
Phoenix, AZ	1.0079
Maricopa, AZ	
Pine Bluff, AR	0.7767
Jefferson, AR	
Pittsburgh, PA	1.0240
Allegheny, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
Pittsfield, MA	0.9946
Berkshire, MA	
Ponce, PR	0.5513
Juana Diaz, PR	
Ponce, PR	
Portland, ME	0.9461
Cumberland, ME	
Sagadahoc, ME	
York, ME	
Portland, OR	1.1292
Clackamas, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Portsmouth-Dover-Rochester, NH	0.9114
Rockingham, NH	
Strafford, NH	
Poughkeepsie, NY	0.9597
Dutchess, NY	
Providence-Pawtucket-Woonsocket, RI	0.9811
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
Provo-Orem, UT	0.9278
Utah, UT	
Pueblo, CO	0.9920
Pueblo, CO	
Racine, WI	0.9299
Racine, WI	
Raleigh-Durham, NC	0.9274
Durham, NC	
Franklin, NC	
Orange, NC	
Wake, NC	
Rapid City, SD	0.8702
Pennington, SD	
Reading, PA	0.9381
Berks, PA	
Redding, CA	1.0803
Shasta, CA	
Reno, NV	1.1202
Washoe, NV	
Richland-Kennewick, WA	0.9688
Benton, WA	
Franklin, WA	
Richmond-Petersburg, VA	0.8897
Charles City Co., VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
Riverside-San Bernardino, CA	1.1536
Riverside, CA	
San Bernardino, CA	
Roanoke, VA	0.8346
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
Rochester, MN	1.0027
Olmsted, MN	
Rochester, NY	0.9558
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
Rockford, IL	1.0245
Boone, IL	
Winnebago, IL	
Sacramento, CA	1.2140
Eldorado, CA	
Placer, CA	
Sacramento, CA	
Yolo, CA	
San Diego, CA	1.2350
San Diego, CA	
San Francisco, CA	1.4945
Marin, CA	
San Francisco, CA	
San Mateo, CA	
San Jose, CA	1.4323

Urban area (constituent counties or county equivalents)	Wage index
Santa Clara, CA	
San Juan, PR	0.5349
Barcelona, PR	
Bayoman, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trojillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Santa Barbara-Santa Maria-Lompoc, CA	1.1428
Santa Barbara, CA	
Santa Cruz, CA	1.2017
Santa Cruz, CA	
Saginaw-Bay City-Midland, MI	1.0646
Bay, MI	
Midland, MI	
Saginaw, MI	
St. Cloud, MN	0.9662
Benton, MN	
Sherburne, MN	
Stearns, MN	
St. Joseph, MO	0.8811
Buchanan, MO	
St. Louis, MO-IL	1.0160
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Salem, OR	1.0416
Marion, OR	
Polk, OR	
Salinas-Seaside-Monterey, CA	1.2211
Monterey, CA	
Salt Lake City-Ogden, UT	0.9508
Davis, UT	
Salt Lake, UT	
Weber, UT	
San Angelo, TX	0.8302
Tom Green, TX	
San Antonio, TX	0.8377
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Santa Fe, NM	0.9362
Los Alamos, NM	
Santa Fe, NM	
Santa Rosa-Petaluma, CA	1.2943
Sonoma, CA	
Sarasota, FL	0.9166
Sarasota, FL	
Savannah, GA	0.8405
Chatham, GA	
Effingham, GA	
Scranton-Wilkes Barre, PA	0.9318
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Monroe, PA	
Wyoming, PA	
Seattle, WA	1.0930
King, WA	
Snohomish, WA	
Sharon, PA	0.9198
Mercer, PA	
Sheboygan, WI	0.9318
Sheboygan, WI	
Sherman-Denison, TX	0.8285
Grayson, TX	
Shreveport, LA	0.8994
Bossier, LA	
Caddo, LA	
Sioux City, IA-NE	0.9248
Woodbury, IA	
Dakota, NE	
Sioux Falls, SD	0.9552
Minnehaha, SD	
South Bend-Mishawaka, IN	0.9605
St. Joseph, IN	
Spokane, WA	1.0823
Spokane, WA	
Springfield, IL	1.0040
Menard, IL	
Sangamon, IL	
Springfield, MO	0.9074
Christian, MO	
Greene, MO	
Springfield, MA	0.9758
Hampden, MA	
Hampshire, MA	
State College, PA	1.0303
Centre, PA	
Steubenville-Weirton, OH-WV	0.9106
Jefferson, OH	
Brooke, WV	
Hancock, WV	
Stockton, CA	1.1743
San Joaquin, CA	
Syracuse, NY	0.9730
Madison, NY	
Onondaga, NY	
Oswego, NY	
Tacoma, WA	1.0325
Pierce, WA	
Tallahassee, FL	0.8531
Gadsden, FL	
Leon, FL	
Tampa-St. Petersburg-Clearwater, FL	0.9125
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
Terre Haute, IN	0.8090
Clay, IN	
Vigo, IN	
Texarkana-TX-Texarkana, AR	0.8071
Miller, AR	
Bowie, TX	
Toledo, OH	1.1101
Fulton, OH	
Lucas, OH	
Wood, OH	
Topeka, KS	0.9955
Shawnee, KS	
Trenton, NJ	1.0014
Mercer, NJ	
Tucson, AZ	0.9639
Pima, AZ	
Tulsa, OK	0.9346
Creeks, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
Tuscaloosa, AL	0.9515
Tuscaloosa, AL	
Tyler, TX	0.9326
Smith, TX	
Utica-Rome, NY	0.8211
Herkimer, NY	
Oneida, NY	
Vallejo-Fairfield-Napa, CA	1.2767
Napa, CA	
Solano, CA	
Vancouver, WA	1.0772
Clark, WA	
Victoria, TX	0.7993
Victoria, TX	
Vineland-Millville-Bridgeton, NJ	0.9580
Cumberland, NJ	
Visalia-Tulare-Porterville, CA	1.1418
Tulare, CA	
Waco, TX	0.8585
McLennan, TX	
Washington, DC-MD-VA	1.1053
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Stafford, VA	
Waterloo-Cedar Falls, IA	0.9432
Black Hawk, IA	
Bremer, IA	
Wausau, WI	0.9457
Marathon, WI	
West Palm Beach-Boca Raton-Delray Beach, FL	0.9431
Palm Beach, FL	
Wheeling, WV-OH	0.8762
Belmont, OH	
Marshall, WV	
Ohio, WV	
Wichita, KS	1.0469
Butler, KS	
Harvey, KS	
Sedgwick, KS	
Wichita Falls, TX	0.8221
Wichita, TX	
Williamsport, PA	0.8804

Urban area (constituent counties or county equivalents)	Wage index
Lycoming, PA	
Wilmington, DE-NJ-MD	1.0125
New Castle, DE	
Cecil, MD	
Salem, NJ	
Wilmington, NC	0.8602
New Hanover, NC	
Worcester-Fitchburg-Leominster, MA	0.9460
Worcester, MA	
Yakima, WA	0.9850
Yakima, WA	
York, PA	0.9340
Adams, PA	
York, PA	
Youngstown-Warren, OH	0.9942
Mahoning, OH	
Trumbull, OH	
Yuba City, CA	0.9970
Sutter, CA	
Yuba, CA	

TABLE 4b.—Wage Index for Rural Areas

Nonurban area	Wage index
Alabama	0.7005
Alaska	1.3815
Arizona	.8886

TABLE 4b.—Wage Index for Rural Areas—Continued

Nonurban area	Wage index
Arkansas	.7124
California	1.0433
Colorado	.8666
Connecticut	1.0013
Delaware	.8236
Florida	.8223
Georgia	.7385
Hawaii	.9318
Idaho	.8516
Illinois	.8188
Indiana	.8104
Iowa	.8070
Kansas	.7927
Kentucky	.7754
Louisiana	.7856
Maine	.8191
Maryland	.8112
Massachusetts	1.0033
Michigan	.9041
Minnesota	.8605
Mississippi	.7215
Missouri	.7644
Montana	.8558
Nebraska	.7751
Nevada	.9817
New Hampshire	.8784
New Jersey [1]	
New Mexico	.8359
New York	.8124
North Carolina	.7650

TABLE 4b.—Wage Index for Rural Areas—Continued

Nonurban area	Wage index
North Dakota	.8463
Ohio	.8609
Oklahoma	.7938
Oregon	1.0029
Pennsylvania	.8807
Puerto Rico	.5547
Rhode Island [1]	
South Carolina	.7232
South Dakota	.7668
Tennessee	.7162
Texas	.7592
Utah	.8782
Vermont	.8387
Virginia	.7833
Virgin Islands [1]	
Washington	.9847
West Virginia	.8414
Wisconsin	.8458
Wyoming	.9100

[1] All counties within the State are classified urban.

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

					RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
1	01	SURG		CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.4100	18.5	14.1	37
2	01	SURG		CRANIOTOMY FOR TRAUMA AGE >17	3.7713	17.9	12.5	35
3	01	SURG	*	CRANIOTOMY AGE 0-17	2.9183		12.7	36
4	01	SURG		SPINAL PROCEDURES	2.5717	16.7	12.4	35
5	01	SURG		EXTRACRANIAL VASCULAR PROCEDURES	1.5659	8.0	6.6	21
6	01	SURG		CARPAL TUNNEL RELEASE	.4381	2.6	2.0	7
7	01	SURG		PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC WITH CC	2.4381	18.9	10.8	34
8	01	SURG		PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	.7266	5.0	3.3	19
9	01	MED		SPINAL DISORDERS & INJURIES	1.2570	10.8	7.0	30
10	01	MED		NERVOUS SYSTEM NEOPLASMS WITH CC	1.2100	11.1	7.6	31
11	01	MED		NERVOUS SYSTEM NEOPLASMS W/O CC	.7694	7.5	5.2	28
12	01	MED		DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9358	9.7	6.9	30
13	01	MED		MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.9291	9.5	7.2	30
14	01	MED		SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.2348	10.4	7.5	30
15	01	MED		TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS	.6281	5.4	4.2	17
16	01	MED		NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0274	8.9	6.6	30
17	01	MED		NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6294	6.0	4.6	19
18	01	MED		CRANIAL & PERIPHERAL NERVE DISORDERS WITH CC	.9247	8.4	6.2	29
19	01	MED		CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6112	5.9	4.4	21
20	01	MED		NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.6089	11.0	7.6	31
21	01	MED		VIRAL MENINGITIS	1.3507	9.1	7.1	30
22	01	MED		HYPERTENSIVE ENCEPHALOPATHY	.7034	5.7	4.6	18
23	01	MED		NONTRAUMATIC STUPOR & COMA	.9438	6.7	4.5	27
24	01	MED		SEIZURE & HEADACHE AGE >17 WITH CC	.9162	6.9	5.1	24
25	01	MED		SEIZURE & HEADACHE AGE >17 W/O CC	.5365	4.6	3.6	15
26	01	MED		SEIZURE & HEADACHE AGE 0-17	.5788	3.6	2.5	13
27	01	MED		TRAUMATIC STUPOR & COMA, COMA >1 HR	1.4368	8.4	4.2	27
28	01	MED		TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 WITH CC	1.1177	8.5	5.4	28
29	01	MED		TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.5528	4.9	3.3	19
30	01	MED	*	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	.3539		2.0	8
31	01	MED		CONCUSSION AGE >17 WITH CC	.6354	5.8	4.1	21
32	01	MED		CONCUSSION AGE >17 W/O CC	.3931	3.7	2.8	12
33	01	MED	*	CONCUSSION AGE 0-17	.2457		1.6	5
34	01	MED		OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	1.1974	8.6	6.0	29
35	01	MED		OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.6032	5.6	4.0	20

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

					RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
36	02	SURG		RETINAL PROCEDURES	.6844	3.6	3.1	10
37	02	SURG		ORBITAL PROCEDURES	.7000	4.0	3.0	13
38	02	SURG		PRIMARY IRIS PROCEDURES	.3780	2.8	2.2	9
39	02	SURG		LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5166	2.1	1.8	5
40	02	SURG		EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.4688	2.6	2.0	7
41	02	SURG	*	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3657		1.6	4
42	02	SURG		INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6610	3.1	2.5	9
43	02	MED		HYPHEMA	.3712	4.5	3.7	14
44	02	MED		ACUTE MAJOR EYE INFECTIONS	.6297	6.8	5.6	20
45	02	MED		NEUROLOGICAL EYE DISORDERS	.5598	4.3	3.3	14
46	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W CC	.6173	5.6	3.8	22
47	02	MED		OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.3570	3.6	2.5	13
48	02	MED	*	OTHER DISORDERS OF THE EYE AGE 0-17	.4018		2.9	13
49	03	SURG		MAJOR HEAD & NECK PROCEDURES	2.8950	15.6	11.8	35
50	03	SURG		SIALOADENECTOMY	.6686	3.4	2.8	9
51	03	SURG		SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.5437	2.9	2.3	8
52	03	SURG		CLEFT LIP & PALATE REPAIR	.7253	3.6	2.8	12
53	03	SURG		SINUS & MASTOID PROCEDURES AGE >17	.6159	3.1	2.3	10
54	03	SURG	*	SINUS & MASTOID PROCEDURES AGE 0-17	.6889		3.2	11
55	03	SURG		MISCELLANEOUS EAR, NOSE & THROAT PROCEDURES	.4593	2.3	1.8	6
56	03	SURG		RHINOPLASTY	.4458	2.3	1.8	7
57	03	SURG		T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.7869	5.1	3.2	20
58	03	SURG	*	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.3097		1.5	3
59	03	SURG		TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.3884	2.0	1.7	5
60	03	SURG	*	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.2616		1.5	3
61	03	SURG		MYRINGOTOMY W TUBE INSERTION AGE >17	.6383	4.3	2.5	17
62	03	SURG	*	MYRINGOTOMY W TUBE INSERTION AGE 0-17	.3089		1.3	3
63	03	SURG		OTHER EAR, NOSE & THROAT O.R. PROCEDURES	1.1477	7.3	4.6	28
64	03	MED		EAR, NOSE & THROAT MALIGNANCY	1.0513	8.4	4.7	28
65	03	MED		DYSEQUILIBRIUM	.4587	4.2	3.5	12
66	03	MED		EPISTAXIS	.4274	3.9	3.2	12
67	03	MED		EPIGLOTTITIS	1.0226	5.9	4.5	20
68	03	MED		OTITIS MEDIA & URI AGE >17 WITH CC	.7164	6.1	5.1	17
69	03	MED		OTITIS MEDIA & URI AGE >17 W/O CC	.5193	4.8	4.0	14
70	03	MED		OTITIS MEDIA & URI AGE 0-17	.4947	3.8	3.1	12

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NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

					RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
71	03	MED		LARYNGOTRACHEITIS	.6005	4.6	3.8	14
72	03	MED		NASAL TRAUMA & DEFORMITY	.4821	4.2	3.1	15
73	03	MED		OTHER EAR, NOSE & THROAT DIAGNOSES AGE >17	.7359	5.5	3.7	22
74	03	MED	*	OTHER EAR, NOSE & THROAT DIAGNOSES AGE 0-17	.3427		2.1	9
75	04	SURG		MAJOR CHEST PROCEDURES	3.0084	14.8	12.3	35
76	04	SURG		OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.0722	12.5	8.8	32
77	04	SURG		OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.0768	6.6	4.3	27
78	04	MED		PULMONARY EMBOLISM	1.4792	10.8	9.0	32
79	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 WITH CC	2.0196	12.5	9.5	33
80	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	1.2317	9.4	7.3	30
81	04	MED		RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.1872	9.5	7.0	30
82	04	MED		RESPIRATORY NEOPLASMS	1.1846	9.3	6.4	29
83	04	MED		MAJOR CHEST TRAUMA WITH CC	.9557	8.3	6.5	27
84	04	MED		MAJOR CHEST TRAUMA W/O CC	.5287	5.4	4.3	17
85	04	MED		PLEURAL EFFUSION WITH CC	1.1391	9.0	6.8	30
86	04	MED		PLEURAL EFFUSION W/O CC	.7681	6.5	4.9	23
87	04	MED		PULMONARY EDEMA & RESPIRATORY FAILURE	1.5622	8.4	6.1	29
88	04	MED		CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.1237	7.8	6.3	24
89	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC	1.2522	9.0	7.2	28
90	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.8330	6.9	5.9	19
91	04	MED		SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.9585	6.3	4.9	23
92	04	MED		INTERSTITIAL LUNG DISEASE WITH CC	1.2694	8.8	6.8	30
93	04	MED		INTERSTITIAL LUNG DISEASE W/O CC	.8208	6.5	5.0	23
94	04	MED		PNEUMOTHORAX WITH CC	1.3776	9.6	7.3	30
95	04	MED		PNEUMOTHORAX W/O CC	.7497	6.5	5.2	21
96	04	MED		BRONCHITIS & ASTHMA AGE >17 WITH CC	.9795	7.2	6.0	20
97	04	MED		BRONCHITIS & ASTHMA AGE >17 W/O CC	.7144	5.7	4.9	15
98	04	MED		BRONCHITIS & ASTHMA AGE 0-17	.5695	3.7	3.0	11
99	04	MED		RESPIRATORY SIGNS & SYMPTOMS WITH CC	.7780	5.5	4.2	19
100	04	MED		RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5234	3.6	2.9	11
101	04	MED		OTHER RESPIRATORY SYSTEM DIAGNOSES WITH CC	.9549	7.1	5.4	25
102	04	MED		OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5618	4.8	3.6	16
103	05	SURG		HEART TRANSPLANT	13.9614	33.7	25.8	49
104	05	SURG		CARDIAC VALVE PROCEDURE W PUMP & W CARDIAC CATH	7.3173	20.3	17.3	40
105	05	SURG		CARDIAC VALVE PROCEDURE W PUMP & W/O CARDIAC CATH	5.7869	15.8	13.1	36

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
106	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.5367	15.9	14.2	37
107	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.2863	12.5	11.1	30
108	05	SURG	OTHER CARDIOTHORACIC OR VASCULAR PROCEDURES, W PUMP	5.5184	16.0	11.3	34
109	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O PUMP	3.8997	12.2	7.3	30
110	05	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP WITH CC	3.6371	15.9	12.6	36
111	05	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP W/O CC	2.2514	10.6	9.3	27
112	05	SURG	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION W/O PUMP	2.0152	10.8	7.1	30
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.3171	18.0	14.2	37
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.7032	13.9	10.3	33
115	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK	4.0553	15.0	12.8	36
116	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	2.7805	8.2	6.6	25
117	05	SURG	CARDIAC PACEMAKER REPLACE & REVIS EXCEPT PULSE GEN REPLACEMENT	1.2164	6.2	4.5	22
118	05	SURG	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT	1.8007	4.2	3.0	14
119	05	SURG	VEIN LIGATION & STRIPPING	.8711	6.3	4.3	23
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.2935	15.6	10.6	34
121	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE	1.7331	11.2	9.4	32
122	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE	1.2412	8.7	7.3	26
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4036	5.3	2.9	23
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.2940	6.3	4.6	24
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	.7674	3.4	2.6	10
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	3.0599	22.7	17.2	40
127	05	MED	HEART FAILURE & SHOCK	1.0191	7.9	6.2	25
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.8489	9.0	8.0	22
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.5683	5.9	3.0	26
130	05	MED	PERIPHERAL VASCULAR DISORDERS WITH CC	.8739	7.7	5.6	29
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5840	5.6	4.0	23
132	05	MED	ATHEROSCLEROSIS WITH CC	.8137	5.8	4.5	18
133	05	MED	ATHEROSCLEROSIS W/O CC	.6763	4.5	3.6	14
134	05	MED	HYPERTENSION	.6071	5.5	4.4	17
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 WITH CC	.9157	6.9	5.2	24
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE > 17 W/O CC	.6075	4.8	3.7	15
137	05	MED	* CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.6315		3.3	26
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS WITH CC	.8426	6.1	4.7	20
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5766	4.4	3.5	14
140	05	MED	ANGINA PECTORIS	.6718	4.9	4.1	14

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
141	05	MED	SYNCOPE & COLLAPSE WITH CC	.6779	5.5	4.4	17
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5234	4.2	3.4	13
143	05	MED	CHEST PAIN	.5499	3.7	3.0	11
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1395	7.8	5.8	28
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6685	5.0	3.8	17
146	06	SURG	RECTAL RESECTION WITH CC	3.4377	18.0	15.6	39
147	06	SURG	RECTAL RESECTION W/O CC	2.1318	13.0	12.0	27
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES WITH CC	3.2644	17.1	14.5	38
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.8291	11.6	10.7	24
150	06	SURG	PERITONEAL ADHESIOLYSIS WITH CC	2.6545	14.9	12.6	36
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.4774	10.0	8.9	24
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES WITH CC	1.6229	10.7	8.4	31
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0581	7.8	6.7	23
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 WITH CC	3.6282	16.8	13.0	36
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE > 17 W/O CC	1.7863	10.6	8.8	31
156	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.8382		6.0	26
157	06	SURG	ANAL & STOMAL PROCEDURES WITH CC	.9223	7.0	5.3	24
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.5375	4.1	3.3	13
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 WITH CC	1.1460	7.5	6.0	23
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	.6844	4.7	4.0	14
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 WITH CC	.7543	5.1	4.0	16
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	.5013	3.3	2.8	9
163	06	SURG	HERNIA PROCEDURES AGE 0-17	.8470	4.4	3.8	12
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG WITH CC	2.2987	12.2	10.7	29
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.4306	8.6	7.9	18
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG WITH CC	1.4589	8.6	7.3	22
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8537	5.4	4.8	12
168	06	SURG	MOUTH PROCEDURES WITH CC	1.4135	8.1	4.9	28
169	06	SURG	MOUTH PROCEDURES W/O CC	.6662	3.5	2.6	11
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	2.7262	16.0	11.4	34
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.3879	9.3	6.7	30
172	06	MED	DIGESTIVE MALIGNANCY WITH CC	1.1825	10.2	6.9	30
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7051	6.6	4.3	26
174	06	MED	G.I. HEMORRHAGE WITH CC	.9841	7.1	5.6	22
175	06	MED	G.I. HEMORRHAGE W/O CC	.6591	5.3	4.4	15

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
176	06	MED	COMPLICATED PEPTIC ULCER	1.0021	7.8	6.1	26
177	06	MED	UNCOMPLICATED PEPTIC ULCER WITH CC	.7814	6.5	5.5	18
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.5831	5.1	4.3	14
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0367	9.0	7.0	29
180	06	MED	G.I. OBSTRUCTION WITH CC	.9012	7.5	5.7	26
181	06	MED	G.I. OBSTRUCTION W/O CC	.5376	5.0	4.1	15
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 WITH CC	.7203	6.1	4.9	19
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	.5244	4.6	3.7	14
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	.4304	3.5	2.4	13
185	06	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	.7573	6.4	4.3	25
186	06	MED	* DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	.4112		2.9	11
187	06	MED	DENTAL EXTRACTIONS & RESTORATIONS	.4561	2.8	2.2	8
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 WITH CC	.9121	6.9	4.9	26
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.4961	4.2	3.0	15
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.8001	5.0	4.0	15
191	07	SURG	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	4.6425	20.5	16.6	40
192	07	SURG	MINOR PANCREAS, LIVER & SHUNT PROCEDURES	3.8128	19.4	14.4	37
193	07	SURG	BILIARY TRACT PROC EXCEPT TOT CHOLECYSTECTOMY WITH CC	2.9912	17.4	14.4	37
194	07	SURG	BILIARY TRACT PROC EXCEPT TOT CHOLECYSTECTOMY W/O CC	1.8416	12.3	9.9	33
195	07	SURG	TOTAL CHOLECYSTECTOMY W C.D.E. WITH CC	2.3422	13.7	12.2	31
196	07	SURG	TOTAL CHOLECYSTECTOMY W C.D.E. W/O CC	1.6795	10.8	10.0	22
197	07	SURG	TOTAL CHOLECYSTECTOMY W/O C.D.E. WITH CC	1.8014	10.9	9.5	26
198	07	SURG	TOTAL CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0954	7.5	6.9	15
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.2400	15.1	12.2	35
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.4643	13.4	9.4	32
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.3817	12.7	8.3	31
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.2030	9.9	7.2	30
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0375	9.2	6.4	29
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.0255	7.7	6.1	24
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA WITH CC	1.2015	9.2	6.7	30
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	.6797	6.0	4.2	24
207	07	MED	DISORDERS OF THE BILIARY TRACT WITH CC	.9150	7.0	5.6	23
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.5795	4.7	3.7	15
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES	2.4158	13.4	12.3	28
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC	2.1768	15.7	13.5	37

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.6024	12.2	11.0	27
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.4004	7.2	6.2	17
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.8206	14.1	10.4	33
214	08	SURG	BACK & NECK PROCEDURES WITH CC	2.2736	15.7	13.1	36
215	08	SURG	BACK & NECK PROCEDURES W/O CC	1.4546	10.6	9.3	26
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.5980	12.9	8.4	31
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	2.4473	17.9	11.3	34
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 WITH CC	1.6072	11.4	9.0	32
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	1.0126	7.0	5.9	20
220	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	.9242		5.3	28
221	08	SURG	KNEE PROCEDURES WITH CC	1.4102	9.4	6.4	29
222	08	SURG	KNEE PROCEDURES W/O CC	.8255	5.0	3.5	19
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.1209	6.8	5.3	22
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	.6721	3.9	3.1	12
225	08	SURG	FOOT PROCEDURES	.6767	4.3	3.2	14
226	08	SURG	SOFT TISSUE PROCEDURES WITH CC	1.3608	10.0	6.8	30
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.6884	4.6	3.4	16
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	.8220	4.3	3.2	14
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.5288	2.8	2.1	9
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	.8559	6.3	4.4	24
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	.8691	5.6	3.5	22
232	08	SURG	ARTHROSCOPY	.8774	5.5	3.2	23
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC WITH CC	1.7128	12.3	9.0	32
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	.9241	6.6	5.0	23
235	08	MED	FRACTURES OF FEMUR	1.1959	13.7	8.2	31
236	08	MED	FRACTURES OF HIP & PELVIS	.8958	10.0	7.2	30
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.5918	6.3	4.7	22
238	08	MED	OSTEOMYELITIS	1.6571	14.5	10.7	34
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	.9492	9.8	7.5	31
240	08	MED	CONNECTIVE TISSUE DISORDERS WITH CC	1.0814	9.4	7.3	30
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6639	6.9	5.4	22
242	08	MED	SEPTIC ARTHRITIS	1.3845	11.5	8.8	32
243	08	MED	MEDICAL BACK PROBLEMS	.7298	7.3	5.6	26
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES WITH CC	.7274	7.5	5.7	26
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.5340	5.6	4.4	19

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					RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
246	08	MED		NON-SPECIFIC ARTHROPATHIES	.5746	5.7	4.6	18
247	08	MED		SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	.5405	5.1	3.9	18
248	08	MED		TENDONITIS, MYOSITIS & BURSITIS	.6085	5.8	4.5	19
249	08	MED		AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	.6807	6.8	4.4	27
250	08	MED		FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 WITH CC	.6672	6.2	4.4	23
251	08	MED		FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	.4144	3.4	2.5	11
252	08	MED	*	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	.3496		1.8	7
253	08	MED		FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 WITH CC	.7847	8.3	5.9	29
254	08	MED		FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	.4534	5.1	3.8	18
255	08	MED	*	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4638		2.9	15
256	08	MED		OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	.6587	5.8	4.1	21
257	09	SURG		TOTAL MASTECTOMY FOR MALIGNANCY WITH CC	1.0411	7.4	6.5	18
258	09	SURG		TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.8450	5.8	5.3	13
259	09	SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY WITH CC	.9978	7.3	5.2	27
260	09	SURG		SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6025	3.6	3.0	11
261	09	SURG		BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	.6173	3.3	2.7	9
262	09	SURG		BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.4291	2.4	2.0	6
263	09	SURG		SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS WITH CC	2.5753	20.4	15.2	38
264	09	SURG		SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.6122	14.7	10.7	34
265	09	SURG		SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.3726	10.3	6.7	30
266	09	SURG		SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	.6851	4.9	3.4	18
267	09	SURG		PERIANAL & PILONIDAL PROCEDURES	.6195	4.5	3.3	15
268	09	SURG		SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	.5949	3.5	2.4	12
269	09	SURG		OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC WITH CC	1.5129	11.3	7.6	31
270	09	SURG		OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC W/O CC	.6790	4.8	3.4	18
271	09	MED		SKIN ULCERS	1.1907	11.4	8.6	32
272	09	MED		MAJOR SKIN DISORDERS WITH CC	1.0294	9.6	7.4	30
273	09	MED		MAJOR SKIN DISORDERS W/O CC	.7193	7.8	6.0	26
274	09	MED		MALIGNANT BREAST DISORDERS WITH CC	1.0412	9.8	6.4	29
275	09	MED		MALIGNANT BREAST DISORDERS W/O CC	.6449	6.1	3.8	26
276	09	MED		NON-MALIGANT BREAST DISORDERS	.5206	4.2	2.9	16
277	09	MED		CELLULITIS AGE >17 WITH CC	.9683	8.8	7.2	25
278	09	MED		CELLULITIS AGE >17 W/O CC	.7048	6.9	5.8	19
279	09	MED		CELLULITIS AGE 0-17	.7370	5.4	4.6	16
280	09	MED		TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 WITH CC	.6168	6.0	4.5	21

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					RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
281	09	MED		TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	.4276	4.5	3.4	16
282	09	MED	*	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.3424		2.2	9
283	09	MED		MINOR SKIN DISORDERS WITH CC	.7673	7.3	5.5	25
284	09	MED		MINOR SKIN DISORDERS W/O CC	.4773	5.0	3.7	18
285	10	SURG		AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	2.9493	22.9	17.4	40
286	10	SURG		ADRENAL & PITUITARY PROCEDURES	2.6967	14.4	11.9	35
287	10	SURG		SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	2.2012	18.6	13.6	37
288	10	SURG		O.R. PROCEDURES FOR OBESITY	1.9519	10.6	8.1	31
289	10	SURG		PARATHYROID PROCEDURES	1.1440	6.9	5.4	20
290	10	SURG		THYROID PROCEDURES	.8374	4.8	4.0	13
291	10	SURG		THYROGLOSSAL PROCEDURES	.4935	2.7	2.3	8
292	10	SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC WITH CC	2.4305	15.8	11.4	34
293	10	SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.0857	8.5	5.8	29
294	10	MED		DIABETES AGE >35	.7455	7.3	6.0	21
295	10	MED		DIABETES AGE 0-35	.7206	5.7	4.5	19
296	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 WITH CC	.8823	7.7	5.8	26
297	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	.5707	5.6	4.5	17
298	10	MED		NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	.7255	5.4	3.2	20
299	10	MED		INBORN ERRORS OF METABOLISM	.8282	6.9	4.8	28
300	10	MED		ENDOCRINE DISORDERS WITH CC	1.0781	9.0	6.9	30
301	10	MED		ENDOCRINE DISORDERS W/O CC	.6737	6.3	4.7	22
302	11	SURG		KIDNEY TRANSPLANT	4.3140	18.9	16.4	39
303	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.7677	14.9	12.7	36
304	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL WITH CC	2.2547	12.9	9.9	33
305	11	SURG		KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.2640	7.3	5.6	26
306	11	SURG		PROSTATECTOMY WITH CC	1.4071	9.9	8.0	29
307	11	SURG		PROSTATECTOMY W/O CC	.8957	6.5	5.5	17
308	11	SURG		MINOR BLADDER PROCEDURES WITH CC	1.4680	9.7	6.9	30
309	11	SURG		MINOR BLADDER PROCEDURES W/O CC	.8567	5.8	4.2	22
310	11	SURG		TRANSURETHRAL PROCEDURES WITH CC	.8867	6.1	4.5	21
311	11	SURG		TRANSURETHRAL PROCEDURES W/O CC	.5557	3.5	2.9	11
312	11	SURG		URETHRAL PROCEDURES, AGE >17 WITH CC	.8111	5.9	4.4	20
313	11	SURG		URETHRAL PROCEDURES, AGE >17 W/O CC	.5193	3.6	2.8	11
314	11	SURG	*	URETHRAL PROCEDURES, AGE 0-17	.4323		2.3	11
315	11	SURG		OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.3956	13.1	8.4	31

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
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TABLE 5

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					RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
316	11	MED		RENAL FAILURE	1.2785	9.0	6.2	29
317	11	MED		ADMIT FOR RENAL DIALYSIS	.3696	2.5	1.8	7
318	11	MED		KIDNEY & URINARY TRACT NEOPLASMS WITH CC	1.0365	9.0	6.0	29
319	11	MED		KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5795	4.9	3.2	19
320	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE >17 WITH CC	1.0130	8.3	6.8	24
321	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.7233	6.4	5.4	18
322	11	MED		KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.6313	4.9	4.1	15
323	11	MED		URINARY STONES WITH CC, &/OR ESW LITHOTRIPSY	.6901	4.8	3.6	16
324	11	MED		URINARY STONES W/O CC	.4928	2.9	2.3	8
325	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 WITH CC	.6706	5.9	4.5	20
326	11	MED		KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	.4303	3.9	3.0	12
327	11	MED	*	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.5511		3.3	26
328	11	MED		URETHRAL STRICTURE AGE >17 WITH CC	.6254	5.1	3.9	17
329	11	MED		URETHRAL STRICTURE AGE >17 W/O CC	.4460	3.5	2.6	12
330	11	MED	*	URETHRAL STRICTURE AGE 0-17	.2788		1.6	5
331	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 WITH CC	.8855	7.3	5.2	27
332	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	.5567	4.7	3.4	17
333	11	MED		OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.7426	4.9	3.6	20
334	12	SURG		MAJOR MALE PELVIC PROCEDURES W CC	1.7850	12.2	11.0	26
335	12	SURG		MAJOR MALE PELVIC PROCEDURES W/O CC	1.4315	9.9	9.3	19
336	12	SURG		TRANSURETHRAL PROSTATECTOMY WITH CC	.9800	7.0	6.1	17
337	12	SURG		TRANSURETHRAL PROSTATECTOMY W/O CC	.7346	5.3	4.9	11
338	12	SURG		TESTES PROCEDURES, FOR MALIGNANCY	.7829	5.5	3.5	23
339	12	SURG		TESTES PROCEDURES, NON-MALIGNANCY AGE >17	.5907	3.8	2.8	13
340	12	SURG	*	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	.4335		2.4	7
341	12	SURG		PENIS PROCEDURES	1.0290	5.2	4.3	15
342	12	SURG		CIRCUMCISION AGE >17	.4469	2.8	2.1	8
343	12	SURG	*	CIRCUMCISION AGE 0-17	.3788		1.7	4
344	12	SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1295	7.5	5.7	24
345	12	SURG		OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	.8224	5.8	4.3	21
346	12	MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, WITH CC	.9207	8.3	5.6	29
347	12	MED		MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5059	4.0	2.7	14
348	12	MED		BENIGN PROSTATIC HYPERTROPHY WITH CC	.6097	5.0	3.6	18
349	12	MED		BENIGN PROSTATIC HYPERTROPHY W/O CC	.3878	2.6	2.0	8
350	12	MED		INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6731	5.8	4.8	16

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					RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
351	12	MED	*	STERILIZATION, MALE	.3333		1.6	5
352	12	MED		OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.4825	3.9	2.8	14
353	13	SURG		PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	2.3057	15.2	12.8	36
354	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG WITH CC	1.5545	10.2	9.1	23
355	13	SURG		UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	.9950	7.1	6.7	13
356	13	SURG		FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.7982	6.3	5.7	14
357	13	SURG		UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIG	2.1480	13.1	11.3	32
358	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY WITH CC	1.2976	9.0	8.1	20
359	13	SURG		UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.9020	6.6	6.3	12
360	13	SURG		VAGINA, CERVIX & VULVA PROCEDURES	.7082	5.3	3.6	19
361	13	SURG		LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.6438	3.9	2.7	13
362	13	SURG		ENDOSCOPIC TUBAL INTERRUPTION	.4102	2.0	1.7	5
363	13	SURG		D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6557	4.8	3.5	16
364	13	SURG		D&C, CONIZATION EXCEPT FOR MALIGNANCY	.4278	2.8	2.2	8
365	13	SURG		OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8957	12.6	9.6	33
366	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	1.0781	9.4	6.1	29
367	13	MED		MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5506	4.9	3.2	18
368	13	MED		INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.8341	7.2	5.7	22
369	13	MED		MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.4910	4.6	3.2	17
370	14	SURG		CESAREAN SECTION W CC	1.0291	7.5	6.4	17
371	14	SURG		CESAREAN SECTION W/O CC	.7173	5.2	4.9	9
372	14	MED		VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.4920	4.3	3.3	12
373	14	MED		VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3216	2.7	2.4	6
374	14	SURG		VAGINAL DELIVERY W STERILIZATION &/OR D&C	.5750	3.6	3.1	8
375	14	SURG	*	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6817		4.4	15
376	14	MED		POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	.3697	3.4	2.6	11
377	14	SURG		POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.0128	4.6	2.9	20
378	14	MED		ECTOPIC PREGNANCY	.7844	4.4	4.1	9
379	14	MED		THREATENED ABORTION	.2775	2.8	2.1	9
380	14	MED		ABORTION W/O D&C	.3088	2.5	1.9	7
381	14	SURG		ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	.3687	1.9	1.5	5
382	14	MED		FALSE LABOR	.1248	1.2	1.2	2
383	14	MED		OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	.3785	4.4	3.2	15
384	14	MED		OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.3268	3.3	2.5	11
385	15			NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.0087	8.3	3.5	26

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
386	15		* EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.6480		17.9	41
387	15		* PREMATURITY W MAJOR PROBLEMS	1.8267		13.3	36
388	15		* PREMATURITY W/O MAJOR PROBLEMS	1.1571		8.6	32
389	15		FULL TERM NEONATE W MAJOR PROBLEMS	1.4987	10.5	7.4	30
390	15		NEONATE W OTHER SIGNIFICANT PROBLEMS	.9827	6.0	4.2	20
391	15		* NORMAL NEWBORN	.2218		3.1	7
392	16	SURG	SPLENECTOMY AGE >17	3.4584	16.1	12.7	36
393	16	SURG	* SPLENECTOMY AGE 0-17	1.5206		9.1	32
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.2716	8.0	5.0	26
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.7233	6.0	4.4	22
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	.3535	2.4	1.7	7
397	16	MED	COAGULATION DISORDERS	1.0053	7.5	5.5	28
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS WITH CC	1.1835	8.5	6.3	29
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6742	5.6	3.9	21
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6568	15.2	11.2	34
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.0746	14.2	9.8	33
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	.9327	6.6	4.6	27
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.4980	11.4	7.8	31
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8002	6.9	4.8	27
405	17		* ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.0407		4.9	28
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.6138	16.0	12.2	35
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.3051	8.6	6.6	29
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	.9107	6.2	4.2	22
409	17	MED	RADIOTHERAPY	1.0755	10.5	7.0	30
410	17	MED	CHEMOTHERAPY	.4693	3.1	2.4	10
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4933	3.9	2.9	13
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.3931	2.6	2.0	8
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG WITH CC	1.1664	10.2	6.9	30
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	.7616	7.4	4.8	28
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.4320	19.3	14.2	37
416	18	MED	SEPTECEMIA AGE >17	1.5809	10.3	7.4	30
417	18	MED	SEPTECEMIA AGE 0-17	.9538	6.6	5.2	21
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9691	8.5	6.7	27
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 WITH CC	.9707	7.5	5.9	24
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6928	5.8	4.7	17

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					RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
421	18	MED		VIRAL ILLNESS AGE >17	.6241	5.5	4.4	16
422	18	MED		VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.5754	4.7	3.4	16
423	18	MED		OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.4992	10.9	7.9	31
424	19	SURG		O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.1015	20.2	11.9	35
425	19	MED		ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.5964	5.9	4.3	21
426	19	MED		DEPRESSIVE NEUROSES	.6548	8.2	6.0	29
427	19	MED		NEUROSES EXCEPT DEPRESSIVE	.6322	8.2	5.6	29
428	19	MED		DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7478	9.9	6.1	29
429	19	MED		ORGANIC DISTURBANCES & MENTAL RETARDATION	.8710	10.2	7.1	30
430	19	MED		PSYCHOSES	.9309	12.9	8.8	32
431	19	MED		CHILDHOOD MENTAL DISORDERS	.7114	8.2	5.8	29
432	19	MED		OTHER MENTAL DISORDER DIAGNOSES	.6870	6.8	4.2	27
433	20			ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.4223	5.0	3.2	20
434	20			ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT WITH CC	.8167	8.3	5.9	29
435	20			ALC/DRUG ABUSE OR DEPENDENCE, DETOX OR OTHER SYMPT TRT W/O CC	.5972	7.6	5.0	28
436	20			ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.9772	13.5	9.0	32
437	20			ALC/DRUG DEPENDENCE, REHAB & DETOX THERAPY	1.3189	17.6	13.7	37
438	20			NO LONGER VALID	.0000		.0	0
439	21	SURG		SKIN GRAFTS FOR INJURIES	1.7400	12.7	7.2	30
440	21	SURG		WOUND DEBRIDEMENTS FOR INJURIES	2.2141	15.4	9.6	33
441	21	SURG		HAND PROCEDURES FOR INJURIES	.7232	3.8	2.4	14
442	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES WITH CC	1.8993	9.7	5.8	29
443	21	SURG		OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.2043	6.8	4.3	27
444	21	MED		MULTIPLE TRAUMA AGE >17 WITH CC	.8044	7.1	5.2	25
445	21	MED		MULTIPLE TRAUMA AGE >17 W/O CC	.4965	4.9	3.7	17
446	21	MED	*	MULTIPLE TRAUMA AGE 0-17	.4796		2.4	10
447	21	MED		ALLERGIC REACTIONS AGE >17	.4719	3.6	2.7	12
448	21	MED	*	ALLERGIC REACTIONS AGE 0-17	.3470		2.9	9
449	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 WITH CC	.7904	6.1	4.5	22
450	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4907	4.1	3.0	14
451	21	MED		POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	.4593	3.9	3.1	11
452	21	MED		COMPLICATIONS OF TREATMENT WITH CC	.8912	6.6	4.5	26
453	21	MED		COMPLICATIONS OF TREATMENT W/O CC	.5105	4.6	3.3	17
454	21	MED		OTHER INJURY, POISONING & TOXIC EFF DIAG WITH CC	.8998	6.7	4.5	26
455	21	MED		OTHER INJURY, POISONING & TOXIC EFF DIAG W/O CC	.4678	4.0	2.9	14

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				RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
456	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.9315	10.1	4.7	28
457	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	2.4720	8.4	4.0	27
458	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.6292	22.4	15.8	39
459	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC	1.8176	14.6	10.0	33
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.0467	9.2	6.4	29
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	.7102	4.3	2.4	16
462	23	MED	REHABILITATION	1.7457	18.2	13.6	37
463	23	MED	SIGNS & SYMPTOMS W CC	.7580	7.0	5.2	24
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4699	4.5	3.4	15
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.3152	2.2	1.8	6
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	.5282	5.0	2.8	20
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4720	4.8	2.6	16
468			UNRELATED OPERATING ROOM PROCEDURES	2.4348	15.1	9.8	33
469		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000		.0	0
470		**	UNGROUPABLE	.0000		.0	0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	4.0816	20.6	18.0	41
472	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	10.2788	27.9	16.6	40
473	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	2.6808	14.6	8.2	31
474	04		TRACHEOSTOMY	11.6887	41.2	32.6	56
475	04	MED	MECHANICAL VENTILATION THROUGH ENDOTRACHIAL INTUBATION	3.1690	12.7	8.8	32

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

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Appendix A—Regulatory Impact Analysis

A. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish an initial regulatory impact analysis for any proposed regulation that meets one of the E.O. criteria for a "major rule"; that is, that would be likely to result in: an annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. In addition, we generally prepare an initial regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a proposed regulation would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat all hospitals as small entities. It is clear that these proposed changes would affect a substantial number of hospitals and the effects on some would be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis in accordance with E.O. 12291 and the RFA.

B. Objectives

We expect these proposed changes to further Congress' original objectives in implementing the prospective payment system. The prospective payment rates create incentives similar to the incentives a hospital would face in pricing and marketing its services in a conventional market. By paying all hospitals the same market-like rate for like services, we let hospitals know in advance the amount they will be paid per discharge. We give them both an opportunity to receive this payment regardless of their specific cost experience, and a strong incentive to operate more efficiently, thus minimizing unnecessary costs. Unlike a cost limitation approach, which achieves savings largely by disallowing Medicare payment for costs that are not reasonable or that are in excess of a specific limit, the prospective payment system achieves savings by intensifying hospitals' incentives to operate efficiently. Thus, our objectives include—

- Restructuring hospitals' economic incentives;
- Basing payment on a system that identifies the product being purchased more accurately than cost reimbursement;
- Reinforcing the role of the Federal government as a prudent buyer of services; and
- Restraining the rate of hospital cost increases, thus moderating the outflow of expenditures from the Medicare trust fund, while maintaining high quality care.

In addition, we share national goals of deficit reduction and restraints on government spending in general. We believe these proposals would further all of our goals while maintaining the financial viability of the hospital industry and assuring assess to high quality care for beneficiaries.

We expect these proposed changes to further these objectives while avoiding or minimizing unintended adverse consequences and ensuring that the outcomes of this payment system are, in general, reasonable and equitable. Thus, the intent is to refine further the prospective payment system without undercutting our objectives.

C. Limitations of Our Analysis

From the outset of the prospective payment system, we have developed increasingly sophisticated models of how the prospective payment system works. Nevertheless, at present, we still have no adequate way to model, and therefore to quantify, many of the potential behavioral changes in response to the prospective payment system on the part of hospitals, hospital managers and employees, physicians, suppliers, or beneficiaries. Further, changes in the private sector, related to both the supply of and demand for health care services, interact with the behavioral incentives created by the Medicare payment system. We do not have the capability to model such interactions, and to attribute the causal relations to the various parties participating in the market place.

We continue to study many aspects of the prospective payment system with the intent of obtaining more adequate data to better quantify the effects of behavioral changes caused by the payment system. Examples of these initiatives include various reports to Congress, as required by section 603 of Pub. L. 98–21, sections 9113 and 9114 of Pub. L. 99–272, and section 9305 of Pub. L. 99–509. These studies will examine many issues, including the feasibility and impact of eliminating or phasing out separate urban and rural DRG prospective payment rates, the need for and the feasibility of developing severity of illness measures, and the quality of post-acute-care. We are also required, under section 603(a)(2)(A) of Pub. L. 98-21, to study and report annually to the Congress on the impact of the prospective payment system.

In addition to these initiatives, we and others (such as the hospital industry) have undertaken a variety of studies on the effects of the prospective payment system, such as examining selected aspects of hospital management behavior under the prospective payment system, to be able to predict better certain effects and outcomes from the system. In spite of these efforts, our ability to attribute the causation of particular changes in the hospital industry directly to particular regulations is still limited. The complexity of the prospective payment system itself, along with numerous other rapidly occurring changes in the hospital environment, make it virtually impossible for us to isolate the effects of any one change in our policy, much less the effects of the entire prospective payment system on the health care industry

Whatever quantitative analysis follows, therefore, as has been the case in previously published regulatory impact analyses, is limited to presenting the projected effects of proposed policy and rate changes on current and projected payment rates. Thus, readers should look upon our analysis as a projection of proposed policy changes rather than as a forecast of anticipated effects of these proposed changes. We are not attempting to predict behavioral responses to our proposals, and we are not generally accounting for changes in such exogenous variables as admissions, lengths of stay, or case mix.

In view of the difficulty we have in quantifying impacts and attributing causality, we believe that the approach we are taking in the specific impact discussions below is the most feasible one. Wherever possible, we have included quantitative representations of proposed changes. As with previously published impact analyses, we are soliciting comments and information about the anticipated effects of these proposed changes on the prospective payment system.

D. Hospitals Included in and Excluded From the Prospective Payment System

Since October 1983, hospitals operating under prospective payment have been phasing into the system according to their own accounting year starting dates. Further, since September 1985, both Massachusetts and New York

have terminated the waivers under which they were excluded from the Medicare prospective payment system, and hospitals in those States have entered that system (Massachusetts hospitals came under the Medicare prospective payment system in October 1985, while New York hospitals began receiving Medicare prospective payments in January 1986). As of September, 1986, about 5,700 hospitals (84 percent of all Medicare-participating hospitals) were operating under the prospective payment system. With the enactment of section 9304 of Pub. L. 99-509, which added section 1886(d)(9) to the Act, the 58 acute care hospitals located in urban and rural areas of Puerto Rico would be included in the prospective payment system effective with discharges on or after October 1, 1987. Also, effective with cost reporting periods beginning on or after October 1, 1987, alcohol/drug hospitals and units that have been excluded from the prospective payment system under § 412.22(c) of the regulations would begin receiving Medicare prospective payment. About 22 hospitals and 352 units would be affected by this provision. Only 169 hospitals remain excluded from the prospective payment system under sections 1814(b)(3) and 1886(c) of the Act (Maryland and New Jersey) or demonstration projects (Rochester and Finger Lakes regions of New York State).

As of September 30, 1986, 743 Medicare hospitals were excluded from the prospective payment system and would continue to be paid on the basis of reasonable cost reimbursement, subject to limits on the rate of their cost increases for FY 1988. These hospitals include psychiatric, rehabilitation, long—term care, and children's hospitals. Another 1,379 psychiatric and rehabilitation units in hospitals subject to the prospective payment system, are excluded from prospective payment as of the same date. These units, too, are paid on the basis of reasonable cost reimbursement, subject to limits on the rate of their cost increases.

More than 400 hospitals are being paid on various special bases under the prospective payment system, as required by statute. They include hospitals accorded special treatment as described in our regulations at 42 CFR Part 412, Subpart G, such as sole community hospitals, and cancer treatment and research hospitals that meet certain conditions. Also included in this group receiving payment on special bases are rural referral centers and hospitals that previously allowed extensive direct billing under Part B of Medicare

E. Inclusion of Puerto Rico Hospitals Under the Prospective Payment System

Using the best data available, we have computed the estimated difference in payments to Puerto Rico hospitals under the rules now in effect (§ 413.40) and under the prospective payment methodology prescribed in the Act. We estimate the combined effect on all Puerto Rico hospitals of implementing prospective payments would be an average payment increase of 4.3 percent over projected payments under the present payment provisions.

In computing this impact, we took into account an estimate of payments for indirect medical education costs and payments to disproportionate share hospitals. To simulate projected payments under the present regulations, we used FY 1988 target payment amounts as an approximation of actual payments. Under payment provisions in effect now, hospitals may receive their actual reasonable costs up to the target amount, plus incentive payments if their actual costs are less than their target amount. Using the target amount as a proxy for actual payments may thus result in an understatement of the increase Puerto Rico hospitals may receive under this proposal.

F. Inclusion of Alcohol and Drug Abuse Treatment Hospitals Under the Prospective Payment System

We are again proposing not to continue the exclusion of alcohol/drug treatment facilities from the prospective payment system. On the basis of our research and that of ADAMHA, we have redefined four of the five DRGs into which alcohol or drug abuse cases fall, and we believe that the proposed reconfigured and recalibrated weights will result in equitable payments that reflect current treatment practices in hospitals furnishing alcohol/drug related services to Medicare beneficiaries. As of September 30, 1986, there were 22 alcohol/drug hospitals and 352 alcohol/drug units located within hospitals already subject to the prospective payment system. Under our proposal to revise § 412 22(c), these hospitals and units would begin receiving prospective payments for discharges occurring during cost reporting periods beginning on or after October 1, 1987. Because our cost data for these hospitals and units are incomplete, we are unable to quantify the payment impact of our proposal on these facilities.

G. Impact on Excluded Hospitals and Units

As noted above, 743 Medicare hospitals and 1,379 units in hospitals included in the prospective payment system currently are paid on a reasonable cost basis subject to the rate-of-increase ceiling requirement of § 413.40. For cost reporting periods beginning in FY 1988, these hospitals would have their individual target amounts increased by the same factor we would apply to update the prospective payment rate effective for FY 1988. This factor is equal to the projected increase in the hospital market basket less two percent, or an increase of 2.7 percent.

The effect this would have on affected hospitals and units would vary depending on each one's existing relationship of costs per discharge to its target amount, and the relative gains in productivity (efficiency) the hospital or unit is able to achieve. For hospitals and units that incur per discharge costs lower than their target amounts, the primary impact would be to affect the level of additional payments made under § 413.40(c). A hospital may receive additional incentive payments for incurring costs that are less than its target amount, but may not receive payments for costs that exceed the target amount. In general, we expect the increased ceiling on payments would maintain existing incentives for economy and efficiency experienced by excluded hospitals and units.

H. Proposed Payment Reductions for Rural Referral Centers

We are proposing to revise § 412.96 regarding the method for computing the payment rates for rural referral centers. We are proposing to pay 97 percent of the applicable urban standardized amounts. This factor is based on recomputing the urban standardized amounts without consideration of hospitals with approved teaching programs located in urban areas. The impact would be to reduce the average prospective payment per case to rural referral centers by three percent We have incorporated the effects of this proposal in the last column of Table I, entitled "Combined Effects", below.

Although the proposed reduction in payments to rural referral centers would be distributed fairly evenly across all affected providers, the actual impact of the reduction would depend a great deal on each hospital's financial position. We have no evidence to suggest that a reduction of this magnitude would result

in serious financial problems for any rural referral center.

I. Analysis of the Quantifiable Impact of Proposed Changes Affecting Rates and Payment Amounts

1. Basis and Methodology of Estimates

The data used in developing the quantitative estimates of changes in payments in Table I., below, are taken from FY 1986 billing data and hospital-specific data for FY 1984. As in previous analyses, we propose to compare the effects of changes being proposed in this document for FY 1988 to our estimate of the payment amounts in effect for FY 1987.

We have treated all hospitals in our database as if they had the same cost reporting period; that is, a cost reporting period coinciding with the Federal fiscal year. Our model does not take into account any prospective behavioral changes in response to these proposals.

The tables and the discussion that follow reflect our best effort to identify and quantify the effects of the changes being proposed in this document. It must be emphasized, however, that as a result of gaps in our data, we are unable to quantify some of the effects of the proposed rule. Most notably, we are unable to quantify the payment effects on alcohol/drug hospitals and units of including them in the prospective payment system.

Another data-related problem affecting the outcome of our analysis is the differences between the data sets used in recalibrating the DRG weights or in the computation of outlier payments and the data set used to simulate payment effects of the proposed rule. We could not utilize all the hospitals in the recalibration or outlier data sets for modeling the impact analysis because in some cases the hospital-specific data necessary for constructing our impact model were missing. Data on hospital bed size and type of control were the data elements most commonly missing. The absent data prevented us from properly classifying and displaying these hospitals in the impact analysis. The missing data, however, did not prevent us from using the discharges from these hospitals in recalibrating the DRG weights or calculating the proposed outlier payments. The result of the mismatch between the sets of hospitals used in the DRG recalibration and outlier payment calculations and the set used in the impact model is to show a slight increase in estimated payments in the impact analysis.

The analysis that follows of the proposed changes examines each of the proposed changes separately. That is, all variables except those associated with the provision under examination were held constant so as to display the effects of each provisions compared to baseline provisions. Thus, in each of columns 1 through 5, we are comparing estimated FY 1987 payments with the payments that would result if only the specified change were made. The final column (6) displays the combined effects of all the previous analyses, as well as reflecting the FY 1988 update factor (which, giving a 2.7 percent increase across the board, generally has a larger effect than all other changes combined), the budget neutrality factor and the payment adjustment for rural referral centers. Also, the combined effects column captures and reflects certain interactive effects which do not present themselves in the analysis of the individual provisions. This last column is the only one in which the effects of simulated FY 1988 payments are reflected.

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TABLE I--ESTIMATED IMPACT OF THE PROPOSED CHANGES IN THE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM

	Number of Hospitals 1/	Statutory Blend Change 2/ (1)	Statutory Change to Case Weighting 2/ (2)	Reclassification and Recalibration 2/ (3)	Proposed Revised Wage Index 2/ (4)	Proposed Outlier Change 2/ (5)	Combined Effect of All Changes 3/ (6)
All Hospitals	5411	0.5	0.0	0.1	0.1	0.2	3.5
Urban by Region							
New England	184	-0.7	0.2	0.1	0.6	-1.0	0.0
Mid Atlantic	335	3.9	-0.4	0.5	0.3	-1.7	2.9
South Atlantic	408	0.7	-0.7	-0.4	0.2	0.8	4.8
East North Central	510	-3.4	-0.2	0.5	-0.4	0.2	-0.3
East South Central	168	5.0	0.1	-0.2	0.1	0.8	8.7
West North Central	194	-0.0	0.4	0.0	0.2	0.5	3.5
West South Central	365	0.8	0.2	0.2	-0.5	0.7	4.4
Mountain	104	1.1	-0.3	-0.1	0.0	1.2	7.3
Pacific	498	0.4	-0.4	0.5	0.3	1.2	4.8
Rural by Region							
New England	56	-1.9	0.9	0.2	0.6	-0.2	1.4
Mid Atlantic	97	-1.7	-0.3	0.6	-0.1	-0.8	-1.4
South Atlantic	346	0.6	1.1	-0.1	0.6	0.2	6.6
East North Central	369	-2.9	1.1	-0.3	0.1	0.1	0.8
East South Central	322	2.5	1.4	-0.5	0.5	0.3	7.1
West North Central	591	1.7	2.5	-1.0	0.3	0.2	5.8
West South Central	446	3.6	1.2	-0.5	-0.4	0.3	7.2
Mountain	256	1.6	1.3	-0.4	-0.1	0.3	5.9
Pacific	162	0.4	1.0	0.0	-0.1	0.6	5.6
Urban Hospitals	2766	0.5	-0.2	0.2	0.1	0.2	3.3
0-99 Beds	683	2.4	-0.2	0.1	0.3	0.5	5.9
100-404 Beds	1673	0.4	-0.2	0.3	0.1	0.5	3.9
405-684 Beds	338	0.3	-0.2	0.1	0.0	0.2	3.0
685 + Beds	72	0.3	-0.2	-0.2	0.0	-1.5	-0.3
Rural Hospitals	2645	0.6	1.2	-0.3	0.2	0.1	4.7
0-99 Beds	2044	1.0	2.0	-0.6	0.1	0.0	6.4
100-169 Beds	399	-0.2	1.2	-0.2	0.1	0.3	4.3
170 + Beds	202	0.7	0.2	0.0	0.2	0.1	2.6

Table I - continued

	Number of Hospitals[1]	Statutory Blend Change[2] (1)	Statutory Change to Case Weighting[2] (2)	Reclassification and Recalibration[2] (3)	Proposed Revised Wage Index[2] (4)	Proposed Outlier Change[2] (5)	Combined Effect of All Changes[3] (6)
Teaching Status							
Non-Teaching	4491	0.7	0.2	0.0	0.1	0.5	4.7
Resident/Bed Ratio Less than 0.25	744	0.1	-0.2	0.2	0.0	0.1	2.7
Resident/Bed Ratio 0.25 or Greater	176	1.1	-0.3	0.2	0.0	-1.0	0.6
Disproportionate Share Hospitals (DSH)							
No Additional Payments	4214	-0.1	0.1	-0.1	0.1	0.3	3.3
Urban DSH 100 Beds or More	880	1.5	-0.3	0.5	0.1	0.0	3.9
Urban DSH fewer than 100 Beds	86	2.8	-0.3	0.3	0.1	1.2	6.8
Rural DSH	231	3.3	1.8	-0.3	0.0	0.3	9.1
Other Special Status							
Sole Community Hospitals (SCHs)	334	0.0	0.5	-0.3	0.1	0.1	4.6
Rural Referral Centers (RRCs)	200	2.6	-0.2	-0.2	0.4	0.2	2.8
Both SCH & RRC	20	0.0	-0.1	-0.2	0.2	0.2	4.4
Rural fewer than 50 beds	1233	2.9	2.2	-0.9	0.1	-0.1	7.7
Type of Ownership							
Voluntary	3256	0.1	0.0	0.1	0.1	0.0	2.7
Proprietary	774	0.7	-0.1	0.4	0.1	1.8	7.2
Government	1357	2.6	0.3	0.0	0.2	-0.2	5.7

1/ Hospital data base excludes Puerto Rico and alcohol/drug hospitals.

2/ Columns 1 through 5 compare payments incorporating each of the specified proposed FY 1988 changes with estimated payments based on parameters published in the Federal Register September 3, 1986 (51 FR 31454) and November 24, 1986 (51 FR 42229). That is, the comparison is not of simulated FY 1988 rates with FY 1987 rates, but of two sets of FY 1987 rates differing only in the incorporation of the change specified in the column title.

3/ This column represents simulated FY 1988 payments compared to estimated FY 1987 payments. It includes the update factor of 2.7 percent required by the Act and the proposed reduction in payments to rural referral centers. This column also reflects the various budget neutrality factors required under the Act as well as interactive effects of the various proposals which we are not able to isolate. As a result, the values in this column are not equal to the sum of the five previous columns.

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2. Statutory Changes

Columns 1 through 3 of Table I indicate the estimated percent change in payments that would result from each of the statutory changes: to a 100 percent national Federal rate; calculation of the average standardized amounts on a discharge-weighted basis rather than on a hospital-weighted basis; and the required annual recalibration of DRG weights.

Under section 1886(d)(1)(A) of the Act, beginning in FY 1988, all hospitals, except sole community hospitals and hospitals in Puerto Rico, will receive prospective payments based entirely on a national urban or rural rate. The effects of this completion of the transition period are shown in column 1 of Table I.

The transition to a 100 percent national Federal blend is a two-fold change. It is the transition from payments based on a blend of Federal and hospital-specific rates to payments based solely on the Federal rate. It also marks the completed transition from a 50/50 regional/national Federal blend to fully national Federal blend.

Hospitals with higher than average hospital-specific rates that are located in regions with regional rates that are higher than the national rates presumably will experience the largest decrease under the change to a fully national Federal rate. Those hospitals with lower than average hospital-specific rates that are located in regions with rates below the national rate presumably would benefit the most from the completion of the transition.

It should be noted that in assessing the impact of the transition to the fully national urban and rural rates, the rates were derived from cost data reflective of hospital operations and behavior prior to the implementation of the prospective payment system. Since the commencement of the prospective payment system, data gathered from our own sources, as well as sources from the private sector (for example, the American Hospital Association), indicate that in response to the prospective payment system, the vast majority of hospitals have succeeded in streamlining their operations and in improving efficiency, thus experiencing substantial operating margins on their Medicare business. Thus, while our impact analysis shows payments to some hospitals decreasing both as a result of the blend change as well as the result of other statutory and regulatory changes being proposed in this document, such reductions do not generally signify negative operating margins.

Section 1886(d)(3)(A) of the Act, as amended by section 9302(c) of Pub. L. 99-509, specifies that urban and rural prospective payment rates for FY 1988 are to be computed on the basis of discharge-weighted rather than hospital-weighted averages. This change would generally benefit rural hospitals. If this were the only change, they would receive, on average, an increase of about 1.2 percent, with small rural hospitals projected to receive the highest increases of 2.1 percent. Urban hospitals would receive nearly uniform decreases of about 0.2 percent, regardless of bed size.

Finally, in accordance with section 1886(d)(4)(C) of the Act (as amended by section 9302(e) of Pub. L. 99-509), we are revising the current DRG definitions and recalibrating the weights to reflect changes in practice patterns, modes of treatment and new technologies. The changes we are proposing are described in section II of the preamble. (The DRGs that have been recalibrated for this analysis also reflect, insofar as possible, the proposed changes to the DRG classification system set forth in a separate notice published elsewhere in this issue of the **Federal Register**.)

Overall, the apparent effect of reclassification and recalibration, applied to estimated FY 1987 payments, would be to increase payments 0.1 percent. As noted earlier, this aggregate increase is largely an artifact of differences between the set of hospitals whose cases are used in our payment simulation model and the set of hospitals whose cases are used to recalibrate the DRG weighting factors.

As a result of reclassification and recalibration, effectively all DRG weights would be revised. The changes in weights for individual DRGs reflect both the use of more recent data and the reclassification of cases consistent with our proposed revised DRG definitions. More than 60 percent of all DRG weights would change by more than 5 percent; of these 289 DRGs, 136 would increase more than 5 percent, and 153 would decrease more than 5 percent. The weights for 58 DRGs would change by more than 20 percent; 32 would increase and 26 would decrease. Almost 60 percent of the 58 DRGs whose weights would change by more than 20 percent are one or both DRGs in pairs from which age over 69 would be eliminated as a basis for DRG classification.

3. Other Changes Proposed

Columns 4 and 5 of Table I show the estimated effects of changes to the wage index and outlier payments that we are proposing in this document.

We are proposing several changes to the wage index required under sections 1886(d)(2)(C)(ii) and 1886(d)(2)(H) of the Act. One change we are proposing, as described in section III of the preamble, is to compute the national average hourly wage by summing total wages for the country and dividing by the total number of hours. Now we compute the average hourly wage for each urban and rural area of the country, sum these averages and divide by the total number of areas. As explained in the preamble, standardizing hospital costs and adjusting hospital payments by the newly constructed wage index would not change a hospital's payments. Thus there is no economic effect from this change in computing the hospital wage index.

In addition to proposing a new method for calculating the hospital wage index, we are proposing to update the index by incorporating hospital hourly wage data for 1984 and using a blended wage index. Column 4 of Table I shows that the blended wage index, considered as the only change from estimated FY 1987 payments, would result in an average payment increase of about 0.1 percent nationally. This increase, we believe, occurs because the localities with increases in their wage index have more discharges than localities with decreases in their wage index. Overall, rural hospitals would receive a slightly higher percentage gain than would urban hospitals (0.2 percent versus 0.1 percent, on average).

As a result of the changes regarding outlier payments that we are proposing in §§ 412.82 and 412.84 of the regulations, many day outlier cases whose adjusted charges exceed the cost outlier threshold would be paid using the cost outlier methodology. Also, because we are proposing to increase the marginal cost factor from 60 percent to 80 percent for outlier cases that exceed the cost outlier threshold, hospitals would generally receive higher payments for these types of cases. Yet, because we are limited, under section 1886(d)(5)(A)(iii) of the Act, to paying between five and six percent of total payments for outlier payments, the total number of cases for which we may make outlier payments would have to be decreased. Column 5 of Table I presents the impact these proposed changes for outlier payments would have an estimated FY 1987 payments, considered separately from other changes.

4. Combined Effects

In the last column of Table I we display the combined effects of the previous five columns plus the effect of

the statutorily mandated update factor of 2.7 percent. This column is the only one in which simulated FY 1988 payments are compared to estimated FY 1987 payments. In addition, this column also incorporates the reduction in payments for rural referral centers of three percent of the urban rate as described in section V.E.4. of the preamble.

We must point out that there are interactions that result from the combining of the various separate provisions analyzed in the previous columns and which we are unable to isolate. Thus the values appearing in column six do not represent merely the additive effects of the previous columns plus the update factor and the reduction in the rates for rural referral centers. Note that the largest changes are the result of the statutory change to a 100 percent national Federal rate and the update factor.

Overall, our analysis shows the proposed changes would increase hospital payments by about 3.5 percent. Urban hospitals would receive an average increase of about 3.3 percent, while rural hospitals would receive, on average, a 4.7 percent increase. Urban hospitals in the East South Central region are projected to receive the largest increase of 8.7 percent. The biggest drop in payments is projected for the rural hospitals in the Mid-Atlantic region. On average, they would receive payment reductions of about 1.4 percent. Among groups of hospitals, rural disproportionate share hospitals and rural hospitals with fewer than 50 beds are projected to receive the largest percentage increases, of 9.1 and 7.7 percent, respectively. Large urban hospitals with over 685 beds are expected to have a slight decrease (0.3 percent) in payments. It should also be noted that despite the proposed reduction in payments to rural referral centers, on average, these hospitals would receive an increase of 2.8 percent.

We project that aggregate payments to the large majority of hospitals will increase over FY 1987 payments. The exception is limited to hospitals with more than 685 beds, urban hospitals in the East North Central region, and rural hospitals in the Mid-Atlantic region.

Table II presents the projected FY 1988 average payments per case for urban and rural hospitals and for the different categories of hospitals shown in Table I, and compares them with the average estimated per case payments for FY 1987. As such, this table presents in terms of the average dollar amounts paid per discharge the combined effects of the proposed changes presented in Table I. That is, the percentage change in average payments from FY 1987 to FY 1988 equals the percentage changes shown in the last column of Table I.

TABLE II.—COMPARISON OF PAYMENT PER CASE

[FY 1988 compared to FY 1987]

	Number of hospitals	Average FY 1987 payment per case	Average FY 1988 payment per case
All hospitals	5411	$4,007	$4,148
Urban by region:			
New England	184	4,671	4,669
Mid Atlantic	335	4,845	4,986
South Atlantic	408	3,975	4,164
East North Central	510	4,641	4,625
East South Central	168	3,680	3,999
West North Central	194	4,494	4,650
West South Central	365	3,996	4,173
Mountain	104	4,423	4,746
Pacific	498	5,061	5,304
Rural by region:			
New England	56	3,311	3,356
Mid Atlantic	97	3,052	3,008
South Atlantic	346	2,548	2,717
East North Central	369	2,757	2,779
East South Central	322	2,211	2,369
West North Central	591	2,477	2,621
West South Central	446	2,314	2,480
Mountain	256	2,748	2,910
Pacific	162	3,243	3,425
Urban hospitals	2766	4,470	4,619
0 to 99 beds	683	3,502	3,710
100 to 404 beds	1673	4,220	4,385
405 to 684 beds	338	4,892	5,038
685 plus beds	72	5,760	5,743
Rural hospitals	2645	2,585	2,705
0 to 99 beds	2044	2,297	2,443
100 to 169 beds	399	2,630	2,743
170 plus beds	202	3,058	3,139
Teaching status:			
Non-Teaching	4491	3,417	3,577
Resident/bed ratio less than 0.25	744	4,631	4,755
Resident/bed ratio 0.25 or greater	176	6,792	6,830
Disproportionate share hospitals (DSH):			
No additional payments	4214	3,724	3,845
Urban DSM 100 beds or more	880	4,880	5,069
Urban DSH fewer than 100 beds	86	3,729	3,983
Rural DSH	231	2,178	2,377

TABLE II.—COMPARISON OF PAYMENT PER CASE—Continued

[FY 1988 compared to FY 1987]

	Number of hospitals	Average FY 1987 payment per case	Average FY 1988 payment per case
Other special status:			
Sole community hospitals (SCHs)	334	2,779	2,906
Rural referral centers (RRCs)	200	3,193	3,282
Both SCH & RRC	20	3,355	3,502
Rural fewer than 50 beds	1233	2,181	2,349
Type of ownership:			
Voluntary	3256	4,167	4,277
Proprietary	774	3,638	3,901
Government	1357	3,518	3,719

BILLING CODE 4120-01-M

APPENDIX B

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 31 1987

The Honorable Jim Wright
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Section 1886(b)(3)(B)(i)(II) of the Social Security Act, as amended by section 9302(a) of P.L. 99-509 (the Omnibus Budget Reconciliation Act of 1986 (OBRA)), sets the FY 1988 applicable percentage increase for the Medicare prospective payment system (PPS) at the market basket rate of increase minus 2 percentage points. Since section 1886(b) of the Act also governs the target rate of increase for hospitals excluded from PPS, the rate of increase for these hospitals is also the market basket rate of increase minus 2 percentage points.

Section 1886(e)(3)(B), as amended by section 9302(e)(3) of P.L. 99-509, requires that the Secretary, not later than April 1, 1987, shall report to the Congress his initial estimate of the applicable percentage increase that he will recommend for FY 1988. This submission constitutes the required report.

The President's FY 1988 budget envisioned an applicable percentage increase of 1.5 percent in the PPS standardized amounts. Based on preliminary data and analysis available at this time, five months before promulgating the final percentage increase and before we have full understanding of the recommendations of the Prospective Payment Assessment Commission (ProPAC), we now believe that a 1.5 percent increase in the PPS standardized amounts may be too low. Current data suggest that the appropriate increase in the standardized amounts could range as high as 2.0 percent.

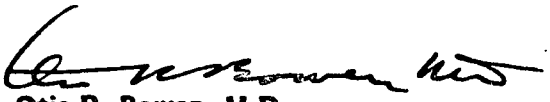
This recommendation is contingent on current projections of relevant data. If current preliminary analysis were to change based on later data or more complete analysis, our recommendation for the applicable percentage increase would change correspondingly. We will make our final recommendation on the appropriate increase nearer the beginning of the new Federal fiscal year based on the latest estimates of all relevant factors, including ProPAC's recommendations.

We believe continued restraint in the PPS system is appropriate for FY 1988. HCFA, the HHS Inspector General, ProPAC, and CBO have all done analyses showing that Medicare payments exceeded hospital costs by 12 - 16 percent in FY 1984. The Inspector General has found similar margins persisting into FY 1985 for a statistically representative sample of hospitals.

After reviewing all relevant data as they become available closer to the beginning of the new fiscal year, we will report again to Congress on our final recommendation for the applicable PPS percentage increase for FY 1988. I urge you to reexamine the issue of the Secretary's authority over the applicable PPS percentage increase and that you again provide me with the discretion to set the applicable PPS percentage increase.

My staff and I look forward to discussing these recommendations with you in the coming weeks.

Sincerely,



Otis R. Bowen, M.D.
Secretary

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 31 1987

The Honorable George H.W. Bush
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

Section 1886(b)(3)(B)(i)(II) of the Social Security Act, as amended by section 9302(a) of P.L. 99-509 (the Omnibus Budget Reconciliation Act of 1986 (OBRA)), sets the FY 1988 applicable percentage increase for the Medicare prospective payment system (PPS) at the market basket rate of increase minus 2 percentage points. Since section 1886(b) of the Act also governs the target rate of increase for hospitals excluded from PPS, the rate of increase for these hospitals is also the market basket rate of increase minus 2 percentage points.

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My staff and I look forward to discussing these recommendations with you in the coming weeks.

Sincerely,

Otis R. Bowen, M.D.
Secretary

APPENDIX C

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

REPORT AND RECOMMENDATIONS TO THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

APRIL 1, 1987

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

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Peggy E. White
Richard Wild, M.D., J.D.
Jo Ann M. Yamamoto
Jeannette A. Younes

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION
300 7th Street, S.W. Washington, D.C. 20024 (202) 453-3986

Stuart H. Altman, Ph.D.
Chairman

Donald A. Young, M.D.
Executive Director

April 1, 1987

The Honorable Otis Bowen, M.D.
Secretary
Department of Health and Human Services
Washington, D.C. 20101

Dear Mr. Secretary:

I am pleased to transmit to you the third annual report of the Prospective Payment Assessment Commission as required by Section 1886 (e)(4) of the Social Security Act as amended by Public Law 98-21. This report contains 28 recommendations updating the Medicare prospective payments and modifying the diagnosis-related group (DRG) classification and weighting factors.

The report also provides background on the Commission's priorities as well as an indication of its agenda for coming years.

Sincerely,

Stuart H. Altman, Ph.D.
Chairman

Enclosure

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Executive Summary

Executive Summary

In its third annual report, the Prospective Payment Assessment Commission (ProPAC) presents recommendations to the Secretary of the Department of Health and Human Services (HHS) on ways to update and improve the Medicare prospective payment system (PPS) for fiscal year 1988. The 28 recommendations in this report reflect the collective judgment of ProPAC's 17 Commissioners regarding issues of substantial importance to beneficiaries, hospitals, and the Medicare program.

The Commission presents these recommendations to comply with its statutory mandate and to contribute to an informed and open debate about hospital payment policy under PPS. The recommendations were produced through a process of agenda setting, information collection, analysis, and deliberation that has continued since the publication of the Commission's previous report in April 1986. The proposed changes are necessary, in the Commission's view, to maintain access to high-quality health care, to encourage hospital productivity and cost-effectiveness, and to permit the adoption of innovative and appropriate technological change. The following major areas are addressed in this year's recommendations.

Updating PPS Payments—The Commission recommends an increase in the level of PPS prices of 2.2 percent for urban hospitals and 3.0 percent for rural hospitals. These update factors are derived by combining several components. One is a 5.4 percent average reduction, to be phased in over the next three years, to reflect recently discovered differences between projected and actual costs during the first year of PPS. This results in a decrease of 1.9 percent for urban hospitals and 1.1 percent for rural hospitals for fiscal year 1988.

The other components are: increases of 4.9 percent for inflation in the hospital market basket, 0.5 percent for scientific and technological advances, and 1.3 percent for real case-mix change; and decreases of 1.0 percent for improvements in hospital productivity, 0.3 percent for shifts in the site of service, and 1.3 percent for expected changes in the case-mix index (CMI). The Commission may change its update recommendation before the beginning of fiscal year 1988 as more recent market basket and case-mix data become available.

Earlier Availability of Cost Data—The Commission urges use of the sampling strategy it has developed to speed up the availability of Medicare Cost Report data. There continues to be critical need for more timely information for decision making. The cost reports provide important information for developing the annual update factor. In addition, they provide the data necessary for assessing the relationship between PPS payments and hospital costs and for analyzing the costs of individual diagnosis-related groups (DRGs). The Commission believes, therefore, that it is important to develop a sample of PPS hospitals with early reporting periods to increase the timely availability of these crucial data.

Incorporating Capital Payments—The Commission believes that the recommendations it advanced last year, with some modifications, represent a sound approach for incorporating capital payments into PPS. The Commission continues to believe that the payment system should ultimately be based on a single, all-inclusive PPS rate. Although the Commission will continue to analyze issues related to capital payment policy, it remains convinced that the transition to incorporate capital payments into PPS should be initiated as soon as possible.

Improving Hospital Labor Market Areas—In its previous annual reports, the Commission recommended improving the way that hospital labor market areas are defined under PPS. These definitions have a substantial effect on the distribution of hospital payments through their impact on the area wage index

adjustment. In this year's recommendation, the Commission provides specific advice for improving these definitions.

Beneficiary Concerns—The Commission is concerned about the financial impact of PPS on beneficiaries and on quality of care. The Commission believes that the portion of inpatient hospital payment borne by Medicare beneficiaries, which has risen as a result of length of stay declines under PPS, should be returned to its pre-PPS level. The Commission also urges a comprehensive evaluation of Peer Review Organizations' (PROs) review of quality of care under PPS.

Rural Hospitals—The Commission has become increasingly concerned about the welfare of beneficiaries who rely on small, isolated rural hospitals. The Commission recommends simplifying the criteria for granting protection against volume fluctuations to Sole Community Hospitals (SCHs) and expanding the number of hospitals eligible for such protection. In general, the Commission believes that payment issues related to the impact of PPS on rural hospitals should be evaluated.

Improvements to the DRGs—The Commission believes that the DRG system is the most appropriate available measure of hospital case mix for PPS. The Commission recommends several specific refinements to the DRG system that can be accomplished by making better use of currently available data. The Commission also believes that it may be desirable to develop longer-term improvements in case-mix measurement by incorporating new data that are not currently collected as part of the discharge abstract. To address some of the inherent deficiencies of case-mix measures, the Commission believes that current outlier payment policy should be evaluated and refined to reduce the financial risk associated with caring for extremely costly cases.

Study of Case-Mix Change—The Commission calls for the development of more complete data and methods to assess changes in case mix over time. In previous years, ProPAC and the Secretary have had difficulty distinguishing between real case-mix change and coding improvement in developing their update factors. The Commission is participating with the Health Care Financing Administration (HCFA) in a study involving the reabstraction of medical records to test and refine methods of ongoing measurement of case-mix change.

AGENDA FOR THE FUTURE

The Commission's mandate requires it to recommend appropriate updates and improvements to PPS. In addition, the Commission believes it has an important role in assessing the impact of PPS on quality of care and other aspects of health care delivery. ProPAC's analytic agenda, therefore, calls for study in three broad areas: improving patient classification and case-mix measurement, improving and updating hospital payment amounts, and assessing quality of care and the effects of PPS on beneficiaries. There are quite a few similarities between ProPAC's current and previous analytic agendas. This reflects the ongoing nature of many of the Commission's responsibilities. During the coming year, ProPAC will undertake the following analytic activities.

Improving patient classification and case-mix measurement:

- Analyses of specific DRGs or groups of DRGs, on a case-by-case basis, to incorporate new technologies and to reflect changes in medical practice;
- Analyses of further generic modifications to the DRG system to better account for variations in resource use related to case complexity, including an examination of the impact of high-cost cases in specialty hospitals and referral centers;
- Monitoring the development and evaluation of alternative case-mix systems that may be used in the future to modify or to replace the DRG system; and
- Studies of other issues related to case-mix measurement, such as outlier payment policy, transfer policy, and the allocation of nursing costs.

Improving and updating hospital payment amounts:

- Studies to further refine the discretionary adjustment factor (DAF), including identification of new data sources and more precise indicators for each of the DAF components;
- Analyses of hospital costs and PPS payments using the most recent data available, including the distribution of payments across different types of hospitals;
- Studies of other issues related to payment amounts, such as the update factor for hospitals excluded from PPS, the impact of PPS on rural hospitals, and the incorporation of capital payments into PPS; and
- Analyses of hospital strategies for improving efficiency and productivity in response to PPS, including changes in services provided.

Assessing quality of care and effects of PPS on beneficiaries:

- Evaluation of quality of care and access to care, including analysis of the impact of hospital financial status on quality of care, and monitoring of the findings of Peer Review Organizations;
- Research to evaluate the availability, provision, and cost of care provided in a hospital after the acute portion of the hospital stay is completed;
- Analyses to monitor possible quality of care problems among targeted groups of beneficiaries, such as those who are frail, disabled, or eligible for both Medicare and Medicaid; and
- Study of the financial effects of PPS on beneficiaries, including the impact of increased cost sharing for hospital stays and increased out-of-hospital expenses.

This report appears shortly after the publication of ProPAC's report to the Congress, *Medicare Prospective Payment and the American Health Care System*, which evaluates the impact of PPS through its second year. The Commission believes that the two reports demonstrate the ongoing need to assess the consequences of PPS. Furthermore, the Commission hopes that its reports continue to lead to the implementation of needed improvements and refinements in PPS.

REPORT ORGANIZATION

Chapter 1 discusses the Commission's role and its processes for fulfilling its mandate, the priorities and concerns that guide its decision making, the status of its previous recommendations, and changes in health care financing and public policy since its last report. Chapter 2 presents ProPAC's 28 recommendations for improving PPS. These recommendations fall into seven broad areas for action by the Secretary during fiscal year 1988:

- Updating PPS payments,
- Incorporating capital payments into PPS,
- Refining adjustments to the PPS payment formula,
- Protecting beneficiaries' interests,
- Improving case-mix measurement,
- Improving DRG classification, and
- Conducting analyses of case-mix change.

Chapter 3 outlines the Commission's proposed analytic agenda. It describes the issues that ProPAC intends to undertake for study during the rest of 1987 and the beginning of 1988.

The Technical Appendixes, a separate volume accompanying this report, contain descriptive and analytical studies conducted by staff and outside experts that served as the basis for the Commission's recommendations.

6

RECOMMENDATIONS FOR FISCAL YEAR 1988

Updating PPS Payments

Recommendation 1: Amount of the Update Factor for PPS Hospitals

For fiscal year 1988, the standardized amounts should be updated by the following factors:

- An average 1.8 percent reduction to reflect first-year PPS cost information. This reduction entails separate adjustments for urban and rural hospitals of −1.9 and −1.1 percent, respectively;
- The projected increase in the hospital market basket (currently estimated at 4.9 percent);
- A discretionary adjustment factor of 0.5 percentage points composed of two allowances:
  - A −0.8 percent allowance for scientific and technological advancement, productivity change, and site-of-care substitution; and
  - A positive allowance for real case-mix change (currently estimated at 1.3 percent).

In addition, the DRG weights should be adjusted to remove any increase in the average DRG weight occurring during fiscal year 1987.

This recommendation reflects the Commission's judgment about the appropriate increase in the level of PPS prices for fiscal year 1988. It assumes that the Commission's other concerns regarding the payment formula and the DRG weighting factors are also addressed in the fiscal year 1988 payment rates. Further, the recommendation is based on the premise that no net reductions or increases in average per-case payments to hospitals will be effected through measures other than the update factor.

Recommendation 2: Adjustment to the Level of Standardized Amounts

The update factor should include an adjustment to lower the standardized amounts an average of 5.4 percent, phased in over three years. The urban standardized amount should be reduced by 5.7 percent, and the rural amount by 3.3 percent. The reductions should be made in three equal increments averaging 1.8 percent, beginning in fiscal year 1988. The adjustments are based on the Commission's judgment about how information on average Medicare costs per case from the first year of PPS should be incorporated into the update factor.

Recommendation 3: Allowance for Scientific and Technological Advancement and Productivity Goals, and Site-of-Care Substitution

For the fiscal year 1988 payment rates, the allowance in the Discretionary Adjustment Factor for scientific and technological advancement, productivity improvement, and substitution in the site of service from inpatient to out-of-hospital settings should be set at minus 0.8 percentage points.

Recommendation 4: Adjustments for Case-Mix Change

For fiscal year 1988, the update of PPS prices should be adjusted for three types of case-mix change in the following manner:

- A positive allowance in the DAF of 0.5 percent for within-DRG case complexity change;
- A positive allowance in the DAF of 0.8 percent for across-DRG real case-mix change; and
- An across-the-board reduction in the DRG weights for increases in the case-mix index during fiscal year 1987, currently estimated to be 1.3 percent.

Recommendation 5: Update Factor for Excluded Hospitals and Distinct-Part Units

For fiscal year 1988, a target rate of increase factor, separate from the PPS update factor, should be used to update payment rates for the group of psychiatric, rehabilitation, and long-

term care hospitals and hospital distinct-part units excluded from PPS. The target rate of increase factor should reflect the projected increase in the hospital market basket for these hospitals, corrected for forecast errors, minus a 0.5 percentage point adjustment for productivity and scientific and technological advancement goals established for PPS hospitals.

For fiscal year 1988, the target rate of increase factor for pediatric hospitals and distinct-part units should reflect the projected increase in the hospital market basket for PPS hospitals, corrected for forecast error, minus a 0.5 percentage point adjustment for the productivity and scientific advancement goals established for PPS hospitals.

Recommendation 6: Timely Availability of Medicare Cost Report Data

Medicare Cost Report data should be routinely collected from a sample of PPS hospitals. The sample should be made up of PPS hospitals with accounting years that begin in the first four months of the Federal fiscal year. Data from this "early return" sample would provide more timely estimates of the costs of PPS hospitals. The Commission believes these data are necessary for assessing the relationship between PPS payments and hospital costs and for analyzing the costs of individual DRGs. The Commission will complete further analyses to determine how an early return sample should be developed for hospitals excluded from PPS but subject to the rate of increase limitations.

Capital

Recommendation 7: All-Inclusive Rate

The Secretary should initiate a transition to a new capital payment method beginning in fiscal year 1988. This method should combine operating and capital cost components in a single prospective payment per case.

Recommendation 8: Level of Federal Capital Payment

Capital payments should be added to the Federal portion of PPS payments for hospital cost reporting years beginning in fiscal year 1988 at a spending level consistent with that established by the Omnibus Budget Reconciliation Act of 1986.

The level for fiscal years 1988 and 1989 should be based on official Medicare inpatient capital spending projections in fiscal year 1987. The projections should include all capital components as presently determined on a reasonable cost basis.

Recommendation 9: Capital Payment Transition

The transition to Federal capital payments under PPS should begin in fiscal year 1988 in the following manner.

- Payments for fixed capital should be phased in over a ten-year period on a straight-line basis.
- Payments for moveable capital should be phased in over a three-year period on a straight-line basis.
- Hospital-specific fixed and moveable capital payment portions should be based on the actual capital costs incurred during each year of the transition.

Recommendation 10: Institutional Neutrality

Until the start of the transition to an all-inclusive PPS payment rate, the Secretary should provide supplemental payments to hospitals for capital costs incurred at other facilities. These costs are not currently reimbursed by Medicare.

Recommendation 11: Capital Exceptions Process

The Secretary should develop an exceptions policy to assist hospitals that are vulnerable to financial hardship when capital payment is included under PPS. Hospital eligibility criteria should emphasize the goal of ensuring continued access of Medicare beneficiaries to high-quality hospital services. The exceptions policy should not be used to protect hospitals simply because they are in financial difficulty. Therefore, a limited dollar pool should be made available with strict criteria to be used in deter-

mining which hospitals would be eligible for a capital payment adjustment.

Adjustments to the Payment Formula

Recommendation 12: Improving the Definition of Hospital Labor Market Areas

The Secretary should adopt improved definitions of hospital labor market areas.

- For urban areas, the Secretary should modify the current Metropolitan Statistical Areas to distinguish between central and outlying areas. The central area should be defined using urbanized areas as designated by the Census Bureau.

- For rural areas, the Secretary should distinguish between urbanized rural counties and other rural counties within each state. Urbanized rural counties should be defined as counties with a city or town having a population of 25,000 or greater.

The implementation of improved definitions should not result in any change in aggregate hospital payments. Furthermore, these definitions should not affect the assignment of hospitals to urban or rural areas for purposes of determining standardized amounts.

Recommendation 13: Improving the Area Wage Index

The Secretary should update the hospital wage data necessary for calculating the area wage index on a regular basis. This updated information should include data on the wages and hours of employment for hospital occupational categories.

Recommendation 14: Extension of Volume Protection to All Isolated, Rural Hospitals

The Secretary should seek legislation to expand the eligibility for a PPS volume adjustment to all isolated, rural hospitals that meet the criteria for Sole Community Hospital status. Eligibility should not be limited to those that have obtained such status in order to maintain 75 percent hospital-specific payments.

Recommendation 15: Clarification of Sole Community Hospital Volume Exception Criteria

Before fiscal year 1988 begins, the Secretary should issue instructions for implementing the Sole Community Hospital volume adjustment that clarify the interpretation of the criteria used to grant such an adjustment. The application process for a volume adjustment should be simplified.

Recommendation 16: Evaluation of Current PPS Payment Policies for Rural Hospitals

The Secretary should complete the studies mandated by Congress in the original PPS and deficit reduction legislation and make them publicly available as soon as possible.

- The study on the feasibility and impact of eliminating or phasing out separate urban and rural DRG prospective payment rates should reflect analyses based on first-year PPS Medicare Cost Reports and, if possible, preliminary findings from the second year of PPS.

- The study of Sole Community Hospitals should be supplemented by an evaluation of the appropriateness of current Medicare payment policies for all small, isolated rural hospitals.

The Commission also intends to examine these issues and will share its findings with the Congress and the Secretary as they are developed.

Recommendation 17: Improvements in Outlier Payment Policy

The Secretary should continue to review outlier payment policy and implement refinements to reflect more accurately the resources hospitals use to treat outlier cases. The Commission is concerned that outlier payments may not adequately protect hospitals from the risk of extremely costly cases. Identifying risk at both the case level and the hospital level should be incorporated into any consideration of policy change. The Commission encourages current research that examines outlier discharges at the hospital, DRG, and case level. The Commission intends to continue its own examination of

outliers and will share the results with the Secretary and Congress.

Beneficiary Concerns

Recommendation 18: Inpatient Hospital Cost-Sharing Requirements

The proportion of inpatient hospital payments borne by Medicare beneficiaries should be returned to its pre-PPS level. This proportion has inappropriately increased as a result of significant declines in length of stay experienced since the beginning of PPS. Furthermore, the structure of inpatient hospital cost-sharing requirements should be consistent with PPS incentives. In particular, current coinsurance and spell of illness requirements need to be reexamined.

Recommendation 19: Evaluating the Results of PRO Quality of Care Review

The Secretary should promptly initiate a comprehensive evaluation of PRO quality of care review activities and findings. The evaluation should assess the impact on quality of care of preadmission, admission, transfer, and readmission review activities. The PRO findings concerning quality of the services furnished during an admission and the health outcome of the episode of care should also be evaluated. The Commission is aware that the SuperPRO is auditing and validating PRO review activities. This effort, however, does not substitute for a comprehensive evaluation of the extent to which PROs are identifying, assessing, and correcting problems related to quality of care.

Patient Classification and Case Mix

Recommendation 20: Improving the Measurement of Hospital Case Mix

The Commission continues to believe that the DRG system is the most appropriate measure of hospital case mix for the Medicare PPS. The Secretary, however, should improve the measurement of case mix to better account for variation in resource use. In the short-term, the Secretary should adopt refinements to the DRG system that make better use of currently available patient data. In the long-term, it may be necessary to develop improvements based on additional sources of patient information not currently available from the discharge abstract.

Recommendation 21: The Use of Patient Age in Defining DRGs

DRGs should not be defined based on the current variable of age greater than 69 and/or presence of a complication or comorbidity (CC). The Commission believes that the resource use for Medicare patients 70 years or older without a CC is significantly lower than for cases with CCs. DRGs should be defined on the basis of the presence or absence of a CC, regardless of age. The Secretary should implement this change for DRGs that currently split on age and CC, and should determine whether other DRGs should also be split on CC.

Recommendation 22: Improving the Use of Complications and Comorbidities in Defining DRGs

The Secretary should revise the current list of complications and comorbidities, and its use in defining DRGs, to ensure more appropriate grouping of Medicare cases for payment under PPS. The Secretary should evaluate several possible approaches, including the development of Major Diagnostic Category (MDC)- or DRG-specific CCs on the basis of resource intensity, and the specification of levels of complexity among the CCs.

Recommendation 23: Updating the Surgical Hierarchies and the List of Operating Room Procedures

The Secretary should evaluate the surgical hierarchies periodically. They should be updated to determine both the clinical appropriateness and resource intensity of the procedures within each class and the relative order of the modified surgical classes. This assessment is necessary to ensure that the hierarchies accurately reflect the relative resource intensity of each operating room procedure. This update process should include clinical input from a broad range of clinicians, including physicians, operating room nurses, medical records experts, and other health care professionals.

Recommendation 24: Improving Grouper Logic and ICD-9-CM Coding

The Secretary should develop and implement changes to ICD-9-CM and the use of these codes by the DRG Grouper. Specifically, the Secretary

should evaluate how the Grouper recognizes ICD-9-CM guidelines and make revisions where necessary to ensure more accurate DRG assignment. More consistent coding guidelines should be developed for the selection of principal diagnosis and sequencing of other diagnoses. Further, noted deficiencies in the ICD-9-CM coding system should be addressed in the next revision (ICD-10). Finally, the Secretary should review all the codes in Chapter 16 of the coding system to establish consistent coding rules and guidelines and help ensure more appropriate DRG assignment.

DRG Classification and Weighting Factors

Recommendation 25: Temporary DRG for the Implantable Defibrillator

Implantable defibrillator cases should be assigned to a new, temporary, device-specific DRG.

Recommendation 26: Temporary DRG for the Cochlear Implant

Cochlear implant cases should be assigned to a temporary, device-specific DRG.

Recommendation 27: Additional Payment for Magnetic Resonance Imaging Scans

For a three-year period, Medicare should pay hospitals an additional amount (called an add-on) to reflect operating costs for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a PPS hospital. The add-on payment should be calculated by the Secretary each year to reflect both changes in the average cost of an efficiently produced scan and the degree to which MRI substitutes for other hospital procedures.

Research on Case-Mix Change

Recommendation 28: Record Reabstraction Study

The Secretary should initiate, as soon as possible, a study of case-mix change based on a reabstraction of medical records of PPS patients. The study should evaluate DRG assignment to distinguish case-mix increases caused by changes in coding practices from changes in treatment patterns and patient mix. The study should serve as the basis on which to develop and refine alternative ongoing data collection methods to monitor case-mix change over time. The Commission will contribute resources to designing, financing, and monitoring this study.

Chapter 1

Introduction and Commission Priorities

Chapter 1

Introduction and Commission Priorities

The Medicare prospective payment system (PPS) for payment of inpatient hospital services was enacted by the Social Security Amendments of 1983 (Pub. L. 98-21). In the same legislation, the Congress created the Prospective Payment Assessment Commission (ProPAC) to advise the executive and legislative branches on maintaining and updating PPS.

This report to the Secretary of the Department of Health and Human Services (HHS) contains the Commission's recommendations for updating and modifying Medicare's prospective payment system for inpatient hospital care. This chapter describes the Commission's role and responsibilities, and the priorities ProPAC has established to govern its functions and decision making. It also summarizes the status of previous ProPAC recommendations and the major policy changes and issues in health care financing during the past year. Chapter 2 contains the Commission's recommendations; Chapter 3 describes analyses and studies ProPAC has under way or plans for the future.

THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION: ITS ROLE, RESPONSIBILITIES, AND PROCESSES

The Congress established ProPAC as a permanent, independent commission with responsibilities related to maintaining and updating the new payment system. In 1986, the Congress expanded the Commission from 15 to 17 members. The Commission members are appointed by the director of the Office of Technology Assessment (OTA), the Congress of the United States. Members are selected, as required by the law, to provide independent expertise in health care delivery, financing, and research. (Biographies of current Commission members appear in this report's appendix.)

Commission Role and Responsibilities

The role of the Commission is to function as a highly knowledgeable, independent panel that provides analysis of and advice on PPS to the executive and legislative branches of the Federal government. This report fulfills the Commission's two primary responsibilities mandated by Pub. L. 98-21. These are to:

- Recommend annually to the Secretary of the Department of Health and Human Services the appropriate percentage change in the Medicare payments for inpatient hospital care, called the "update factor," which is applied to the previous year's payment rates.

- Consult with and recommend to the Secretary of the Department of Health and Human Services necessary changes in diagnosis-related groups (DRGs), including advice about establishing new DRGs, modifying existing DRGs, and changing the relative weights of the DRGs.

Following the report and recommendations submitted to the Secretary for consideration in rulemaking, each fall the Commission reports to the Congress its evaluations of adjustments made by the Secretary. ProPAC also reports to the Congress annually about the overall effects of PPS on American health care delivery and financing, and provides other reports and analyses to the Congress as requested.

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Commission Processes

The Commission has established a subcommittee structure to facilitate its work. ProPAC holds open meetings and solicits comment and involvement from groups or people with information relevant to its responsibilities. To enhance the Commission's communications with the public, all meetings are announced in the *Federal Register*. ProPAC maintains a mailing list and schedules public comment periods at each open Commission and subcommittee meeting. Formal notice has been published in the *Federal Register* (50 Fed. Reg. 1657 [1985]) describing the process for interested parties to use in submitting information to the Commission. The Commission also has adopted a general policy statement. This statement, along with information about the subcommittee structure and Commission meeting dates, appears in this report's appendix.

The Commission requested and received, through the congressional appropriations process, a budget of $3.3 million to carry out its work in fiscal year 1986; a slight increase to approximately $3.4 million was approved for fiscal year 1987. These funds support the administrative, research, and analytic work of the Commission and an executive director and staff of no more than 25.

This report does not explain the background or operation of the prospective payment system. Rather, the Commission assumes that the reader has a general understanding of PPS. Historical perspectives on PPS and a full description of the system are found in previous Commission reports.

PRIORITIES AND CONCERNS OF THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

In its previous reports, the Commission set forth a list of cross-cutting priorities to guide all its analysis and decision making. These priorities continue to serve as the underlying basis of ProPAC's work.

Maintaining Access to High-Quality Health Care—The Commission's first priority is maintaining access to high-quality health care. With its altered financial incentives for hospitals, PPS has created the challenge of maintaining quality health care while restraining health care costs. Hospitals that are paid a fixed amount per type of case by Medicare and other payers can no longer be indifferent to the resources expended for patient care. PPS encourages a reduction of hospital inputs—tests, special procedures, supplies, equipment, personnel time, and hospital days—because hospitals can lower their costs only by controlling resources devoted to inpatient stays. Clearly, as the increase in hospital spending is slowed and cost savings are realized, the need to develop methods to detect adverse effects on quality and access is intensified.

The Commission has persisted in its examination of issues related to quality of care and plans to continue this work in the future. The DRG classifications and weights must be modified appropriately to reflect changes in medical practice. Similarly, the update factor must be adequate to enable hospitals to expend the resources required to maintain the appropriate amount and type of care.

Encouraging Hospital Productivity and Long-Term Cost-Effectiveness—The Commission's concern for maintaining quality under PPS is accompanied by a second priority of promoting productivity and long-term cost-effectiveness in the health care system. PPS uses the diagnosis-related groups to classify patients and define the hospital product. Hospital care is only one of many "products" that contribute to improvement in health status. Other modes of care outside of the hospital also contribute to improved health. Thus, the Commission will look beyond the hospital setting to assess and measure productivity in the context of PPS.

PPS provides incentives for improving productivity and cost-effectiveness of services. It also creates incentives to move services to other settings. If these services can be provided at lower cost and equal quality in other settings, such a move should be encouraged. The Commission is also concerned that the emphasis on reducing costs may deter the adoption of new services which may initially increase costs, even though in the long-run they may improve patient care,

productivity, and/or cost-effectiveness. The Commission's work will continue to carefully assess this potential problem.

Facilitating Innovation and Appropriate Technological Change—The Commission believes the Medicare prospective payment system should have an unbiased effect on technological advancement. Consequently, a third priority of the Commission is facilitating innovation and appropriate technological change.

PPS payment levels should be neutral concerning the development, diffusion, or adoption of new technologies and practices. In reviewing the potential effects of PPS on the adoption of new technologies and practices, the Commission must consider whether payment policies and amounts are sufficient to enable hospitals to adopt them. One approach the Commission has chosen to ensure appropriate technological innovation and change under PPS is to adjust the current DRG classifications and weights to reflect changes in technology and practice patterns. In addition, the Commission will continue to consider scientific and technological advances explicitly, as part of its recommendations related to the update factor.

Maintaining Stability for Providers, Consumers, and Other Payers—A fourth priority of the Commission is the maintenance of a stable environment for providers, consumers, and other payers. The Commission believes that in an atmosphere where health care delivery and financing are changing rapidly, its recommendations should provide as much predictability and stability as possible. During its deliberations, the Commission has identified many problems, which are described throughout this report. Equitable and workable solutions are much more difficult to develop. The Commission has made only those recommendations it considers most important and amenable to well-informed decision making.

Decision Making Based on Reliable, Timely Data and Information—The Commission's final priority is to base its decisions on reliable, timely data and information. The Commission's major contribution to the maintenance and evolution of PPS is the development of recommendations grounded in quantitative data and analytic reasoning, tempered by judgment and experience. The use of accurate, timely data, analyzed and presented without bias as a basis for decision making, is a critical priority of the Commission and its staff. The Commission will continue to inform itself with the best and most timely information available before making recommendations.

STATUS OF PREVIOUS PROPAC RECOMMENDATIONS

As PPS has evolved over the past three years, ProPAC has examined a number of important policy issues. The Commission has brought to the attention of the Secretary and the Congress problems that it believes could compromise the effective delivery of high-quality hospital care to Medicare beneficiaries. In some cases, the Secretary has made important adjustments to PPS. In others, the Congress has legislated necessary changes. ProPAC believes still other adjustments will be needed to ensure that PPS is responsive to constantly changing medical practice.

Adjustments to PPS fall into two broad categories. The first concerns the annual change in total payments to hospitals, the update factor. The second focuses on the distribution of payments across diagnostic categories and among hospitals.

In 1985 and 1986, Congress considered the level of the update factor proposed by the Secretary as well as that recommended by ProPAC. In both years, Congress legislated an update factor amount which was higher than that recommended by the Secretary and lower than ProPAC's recommendation. Furthermore, in both years the Commission made recommendations related to the distributional impacts of PPS. It proposed an adjustment for disproportionate share hospitals, which has been enacted by the Congress and implemented.

The Commission also expressed concern that the movement to full Federal rates might have unforeseen distributional impacts, and recommended a pause in the transition to these rates. This pause was also enacted, slowing the

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movement to Federal rates to allow additional time for analysis and preparation for this major change in payments.

The Commission has indicated that part of the increase in beneficiary cost sharing is inappropriate. ProPAC recommended that the Secretary seek legislative changes in the formula used to compute the inpatient hospital deductible. The Congress has enacted a new, more equitable formula for calculating the deductible.

In some cases, ProPAC's recommendations have been implemented later than contemplated by the Commission. Particularly noteworthy is the recommendation to recalibrate the DRG weights annually. This will be done, but not until fiscal year 1988. A number of technical but important improvements in the hospital market basket also fall into this category.

Finally, the Commission has made recommendations addressing problems related to new technologies, changing practice patterns, and other coding and case-mix measurement problems. In formulating these recommendations, ProPAC carefully reviewed all relevant data and sought the advice of acknowledged experts throughout the country. While many of these recommendations have not been implemented, the Commission believes such changes are necessary to keep PPS consistent with changes in hospital service patterns.

CHANGES IN HEALTH FINANCING AND PUBLIC POLICY SINCE APRIL 1986

The past year has seen the passage of two reconciliation acts by Congress: the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) and the Omnibus Reconciliation Act of 1986 (OBRA 1986). Many of the legislative changes mentioned above were enacted in these two laws.

While there was no change in capital payment policy during 1986, Congress expressed its intent to reconsider the issue of payment for capital-related costs to hospitals under PPS in the 100th Congress. In OBRA 1986, however, Congress reduced the amounts of capital-related payments to PPS hospitals by 3.5 percent for portions of cost reporting periods in fiscal year 1987, 7 percent for fiscal year 1988, and 10 percent for fiscal year 1989. Congress also stated that if it did not legislate changes in capital payment policy, the Secretary would be permitted to include capital in PPS beginning in fiscal year 1988. Consequently, in its fiscal year 1988 budget, the administration proposed to gradually incorporate Medicare payment of hospital capital costs into PPS at the level envisioned by Congress in OBRA 1986. The proposal included a ten-year transition for fixed plant and a three-year transition for moveable equipment.

Other policy issues that emerged during this time are of equal importance and concern. Overall deficit reduction continued to be high on congressional agendas. The proposed expansion of the Medicare program to cover catastrophic illnesses will also occupy a great deal of time in Federal health policy debates during the coming year. It is expected that Congress will examine a number of proposals related to catastrophic coverage policy. ProPAC is interested in the decisions concerning Medicare coverage of catastrophic illness as they relate to the Commission's mandate and responsibilities. Consequently, ProPAC will monitor congressional hearings and actions on this and other proposed changes in health financing.

Chapter 2

Recommendations

Chapter 2

Recommendations

The Commission's recommendations for fiscal year 1988 are the result of an ongoing process of agenda setting, information collection, analysis, and deliberation. ProPAC selects issues for consideration to conform with its statutory mission and to contribute to an open policy debate on matters of substantial importance to beneficiaries, hospitals, and the Medicare program.

The recommendations reflect the collective judgment of the 17 Commissioners. In certain cases, however, individual Commissioners did not agree with the majority opinion.

Some recommendations, such as those pertaining to the annual update of payment rates, will be repeated in similar format every year. In other instances, the Commission has reconsidered and amplified or modified past recommendations on the basis of new evidence. In addition, certain issues were examined for which no recommendations were developed. Because these issues receive little or no attention elsewhere in the report, they are briefly discussed later in this chapter.

Concern for reducing the Federal deficit and attaining a balanced budget continued to dominate public policy debates while these recommendations were being developed. It is the role of Congress rather than the Commission, however, to determine the extent to which Medicare payments should be influenced by budgetary objectives. While ProPAC did not explicitly take budgetary concerns into account, the recommendations were developed in recognition of a constrained fiscal environment. Furthermore, the Commission believes that budgetary pressures intensify the need to address distributional and technical payment issues that may bear on the quality of care furnished to Medicare beneficiaries.

The following discussion presents an overview of the Commission's 28 recommendations for fiscal year 1988. The full text and discussion of each recommendation follow the overview. Background information, statistical analyses, and alternative options are in the Technical Appendixes. The issue areas addressed by the Commission this year are:

- Updating PPS payments,
- Capital,
- Adjustments to the PPS payment formula,
- Beneficiary concerns,
- Patient classification and case mix,
- DRG classification and weighting factors, and
- Research on measuring case-mix change.

OVERVIEW OF THE COMMISSION'S RECOMMENDATIONS FOR FISCAL YEAR 1988

Updating PPS Payments

In making recommendations on the update factor, the Commission is required by the PPS statute to:

> . . . take into account changes in the hospital market basket . . ., hospital productivity, technological and scientific advances, the quality of care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient services.

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The Commission must report its recommendations on the update factor to the Secretary of Health and Human Services no later than April 1 of each year (March 1 beginning in 1988), and

> . . . taking into consideration the recommendations of the Commission, the Secretary shall determine . . . the percentage change . . . which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

Recommendation 1 reflects the Commission's overall judgment of the appropriate change in the level of PPS prices for fiscal year 1988 on the basis of currently available data. The Commission recommends an increase in PPS prices of 2.2 percent for urban hospitals and 3.0 percent for rural hospitals. Several of the components of the update factor may change as a result of receiving new data before publication of the final rules for fiscal year 1988. The Commission will publicize revisions to its recommendation on the update factor, if any, during the rulemaking process.

Recommendation 2 is a new update factor component this year. It calls for an average reduction in the standardized amounts of 5.4 percent, to be phased in over a three-year period. In fiscal year 1988, this would represent an adjustment to the standardized amounts of -1.9 percent for urban hospitals and -1.1 percent for rural hospitals. These adjustments are based on an examination of first-year PPS cost data, which showed that actual costs were substantially below the projected costs on which first-year payments were based. The Commission's recommendation allows hospitals to retain, in the payment base, part of the savings associated with efficiency gains under PPS. It also recognizes that some of these savings have been recouped by the Medicare program through relatively low updates since the first year of PPS.

Recommendations 3 and 4 cover the discretionary adjustment factor. Recommendation 3 consists of a combined allowance for scientific and technological advancement and productivity goals, and for changes in the site of services delivered to Medicare hospital inpatients. Recommendation 4 is an allowance for changes in patient mix and complexity that are not otherwise provided for in the PPS payment structure. It also includes a recommended adjustment to offset expected change in DRG weights.

Recommendation 5 satisfies the Commission's statutory obligation to recommend an update factor for hospitals and distinct-part units of hospitals excluded from PPS. Because these hospitals and units are not subject to as wide a range of behavioral incentives as PPS hospitals, the Commission's recommendation has fewer components than for PPS hospitals.

Recommendation 6 underscores the Commission's conviction that Medicare Cost Report data should continue to be available for the update recommendation and other purposes. A sampling strategy should be used to make these data available on a more timely basis.

Capital

When the Commission adopted the capital payment recommendations presented in the April 1986 report, it thought that a new PPS capital payment policy would be initiated in fiscal year 1987. The Congress, however, decided to defer implementation of capital payment under PPS until fiscal year 1988 at the earliest. In light of this postponement, the Commission decided to continue to examine the capital payment issue during the past year. The results of the Commission's deliberations are presented in Recommendations 7 through 11.

The Commission believes that the recommendations it advanced last year, with some modifications, represent a desirable approach toward bringing capital payment under PPS. In particular, the Commission believes that the payment system should ultimately be based on a single, all-inclusive PPS rate. The Commission considered but rejected the option of replacing its approach with an alternative based on grandfathering payments for capital costs obligated before a certain date.

ProPAC's capital recommendations this year modify and expand those made last year. The most significant change is the replacement of formerly recommended levels of capital

payment with spending levels that are consistent with those specified in OBRA 1986. While the Commission will continue to analyze technical issues related to capital payment, it remains convinced that the transition to incorporating capital payment in PPS should be initiated as soon as possible.

Adjustments to the PPS Payment Formula

The Commission continues to be concerned with achieving technical improvements in the way PPS payments are calculated. Such improvements will result in a more equitable distribution of payments among hospitals and a lower risk of access and quality problems for beneficiaries. Recommendations 12 through 17 address several potential adjustments to the methods of calculating PPS payments.

In its 1985 and 1986 April reports, the Commission recommended improving the way that hospital labor market areas are defined under PPS. These definitions substantially affect the distribution of hospital payments because they are used for application of the area wage index adjustment to PPS prices for every hospital. In Recommendations 12 and 13, the Commission provides specific advice on how improvements in this area should be accomplished.

Based on its analysis, the Commission recommends a specific methodology for recognizing wage variation between central city and outlying metropolitan areas and between urbanized and nonurbanized rural counties within each state. In addition, ProPAC recommends periodic updating of hospital wage data so that the area wage index will be based on reasonably current information.

The Commission also amplifies its prior concerns about the treatment of rural hospitals under PPS in Recommendations 14 through 16. Despite some technical improvements in payment calculations benefiting rural hospitals, the Commission continues to be concerned about the welfare of beneficiaries who rely on isolated rural hospitals for Medicare services.

The Commission recommends specific modifications to the way in which adjustments for volume fluctuations are currently paid to some rural hospitals under PPS. The Commission believes that such adjustments should be made available to all hospitals that meet the criteria for designation as a Sole Community Hospital (SCH), not just to hospitals that apply for and receive this designation. The Commission further believes that the process for obtaining a volume adjustment should be clarified and simplified. The combined effect of these recommendations would be greater protection of isolated rural hospitals against losses associated with wide fluctuations in patient census.

More generally, the Commission believes that basic payment issues related to the impact of PPS on rural hospitals ought to be evaluated. It urges the Secretary to complete and publicize findings from studies on this subject. Availability of more complete information on rural hospital experience under PPS will enable the Secretary, ProPAC, and the Congress to devise alternative strategies to resolve any remaining problems.

Finally, in Recommendation 17, the Commission states its belief that current outlier payment policy ought to be evaluated and refined. The Commission intends to continue work in this area to complement studies under way in the Health Care Financing Administration (HCFA) and other agencies. These studies are designed to achieve a more equitable method of tempering the financial risk associated with caring for extremely costly cases.

Beneficiary Concerns

Concern for beneficiary welfare enters into virtually all the Commission's deliberations and resultant recommendations. In addition, many of the Commission's resources are expended on assessing the consequences of PPS for beneficiaries, such as researching the effects of PPS on quality of care. In Recommendations 18 and 19, the Commission addresses two specific issues, one financial and one related to quality, where improvements in beneficiary welfare under PPS may be accomplished.

In Recommendation 18, the Commission expresses its belief that the proportion of inpa-

tient hospital payments borne by Medicare beneficiaries, which has risen due to declining length of stay under PPS, should be returned to its pre-PPS level. The Commission is aware that reconsideration of the Medicare cost-sharing requirements is under way. It believes that changes in these requirements should make them more consistent with PPS incentives.

The Commission has commented in past reports on the activities of Peer Review Organizations (PROs) as they affect Medicare beneficiaries. In Recommendation 19, the Commission urges the Secretary to initiate a comprehensive evaluation of PRO quality of care review activities. Information obtained from such an evaluation would be extremely helpful in assessing the quality of care Medicare beneficiaries receive under PPS and in identifying potential problem areas for further investigation.

Patient Classification and Case Mix

The Commission continues to believe that the existing DRG system is the most appropriate of the available measures of hospital case mix for PPS. In Recommendation 20, however, ProPAC concludes that available data can be used to refine the DRG system. It makes specific suggestions in Recommendations 21 through 24. In addition, ProPAC believes that it may be desirable to develop longer-term improvements in case-mix measurement based on new data that are not currently available from the discharge abstract.

The Commission recommends eliminating age as a determinant of DRG assignment, revising the list of complications and comorbidities (CCs) used in DRG assignment, and periodically updating the surgical hierarchies used to assign DRGs in cases that involve multiple procedures. Individually and collectively, these modifications would result in more homogeneous DRGs and a better system of case-mix measurement based on existing data.

In Recommendation 24, ProPAC stresses again the necessity and feasibility of improving the International Classification of Diseases (ICD-9-CM) coding system and its use in DRG assignment. In particular, the Commission makes specific suggestions for improvements in the DRG Grouper computer software that groups cases into DRGs. Recommendations made last year in this area remain in effect.

DRG Classification and Weighting Factors

The PPS statute requires the Commission to:

> . . . consult with and make recommendations to the Secretary with respect to the need for adjustments [in classification and weighting factors] . . . based on its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities.

These adjustments refer to the system for:

> . . . classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

They also relate to the assignment of:

> . . . an appropriate weighting factor [to each diagnosis-related group] which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

Recommendations 25 through 27 provide payment guidelines for three relatively new hospital technologies: implantable defibrillators, cochlear implants, and magnetic resonance imaging (MRI) scans. Implementing these recommendations will help ensure that PPS does not inappropriately impede the development and availability of quality-enhancing new technologies to Medicare beneficiaries.

Research on Measuring Case-Mix Change

The Commission continues to believe that decisions about updating and modifying PPS payments to hospitals ought to be based, to the extent possible, on comprehensive data and analysis. Many of the recommendations described above, such as sampling Medicare Cost Reports to obtain more current PPS cost data,

include suggestions for accomplishing this general objective.

Recommendation 28 addresses the need to develop more complete data and methods for assessing case-mix change over time. Distinguishing real case-mix change from coding change has been problematic for both ProPAC and HCFA in developing their update factor computations. The lack of thorough information has also been a source of dispute between the government and hospitals whose payments are affected by determinations in this area. Accordingly, ProPAC and HCFA have initiated plans to ameliorate this problem through research based on a reabstraction of medical records. The Commission hopes that over time many such collaborative arrangements between ProPAC and HCFA will be developed.

ISSUES ADDRESSED THAT DID NOT RESULT IN RECOMMENDATIONS

The Commission addressed several issues that did not lead to recommendations. These were related to recalibration, pacemakers, penile prostheses, adjusting the standardized amounts for costly devices, and coding practices.

Recalibration

In its April 1986 report, the Commission recommended recalibration of the DRG weights on an annual basis. Because annual recalibration is now required under OBRA 1986, the Commission decided it was unnecessary to repeat its recommendation. It may, however, choose to comment on the manner in which the DRG weights are recalibrated. In particular, the Commission will continue its analysis of whether recalibration is most appropriately carried out using charge data alone, or charge data adjusted for costs. Results of the analysis will be used to evaluate the data and methods HCFA employs to recalibrate the DRG weights.

Pacemakers and Penile Prostheses

In its April 1986 report, the Commission recommended that the DRGs involving implantation of cardiac pacemakers should each be divided into two DRGs: one for cases involving single-chamber pacemakers, and one for cases involving dual-chamber or functionally similar pacemakers. The Commission continues to be concerned that the current financial incentive to implant the least costly pacemaker device could have an adverse impact on quality of care. To date, however, there is no evidence that this has occurred. In addition, further analysis of costs and charges for the pacemaker DRGs has led the Commission to conclude that creating two sets of DRGs would only partially address the problem. Consequently, the Commission did not repeat the recommendation this year.

The Commission understands that the results of a HCFA analysis of pacemaker registry data will soon be completed, and that the ICD-9-CM Coordination and Maintenance Committee is developing new pacemaker procedure codes. The Commission will continue to study the pacemaker DRGs using this new information.

The Commission also recommended removing cases that involve implantation of penile prostheses from DRG 341 and reassigning them to a unique DRG. Based on additional analysis of device costs and charges within DRG 341, the Commission is no longer convinced that creating a new DRG for penile implants is necessary.

ProPAC continues to be concerned that payment considerations do not lead hospitals to deny patients access to new technologies like advanced cardiac pacemakers and penile prostheses. The Commission will therefore continue to monitor the use of these technologies and to examine alternative DRG classifications for them.

Adjustment of the Labor and Nonlabor Portions of the Standardized Amounts

In its April 1986 report, the Commission recommended adjusting the portions of the standardized amounts attributed to labor and nonlabor costs for certain DRGs that frequently involve the use of expensive devices. This recommendation was based on ProPAC analysis showing that hospitals in high-wage areas receive higher payment relative to costs for these DRGs compared with hospitals in low-wage areas.

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The financial impact of adjusting the standardized amounts to account for the variation in labor portions across DRGs is uncertain. In light of this, the Commission decided not to repeat the recommendation this year. The Commission does believe, however, that this issue deserves further attention. ProPAC will continue to monitor how the area wage index and portions of the standardized amounts attributed to labor and nonlabor costs may affect the distribution of PPS payments.

Coding

In 1986, the Commission made several recommendations concerning the use of ICD-9-CM coding. ProPAC remains convinced that the coding system must be as accurate and up-to-date as possible. It also believes that coding decisions made for payment purposes should adhere to recognized coding rules and guidelines. The Commission previously identified a number of deficiencies in the process governing coding decisions and suggested specific actions to be taken by the Secretary. While there has been some progress, many of these deficiencies are still unresolved. Therefore, the Commission stands by its previous recommendations regarding ICD-9-CM and urges the Secretary to reconsider those that have not yet been implemented.

RECOMMENDATIONS FOR FISCAL YEAR 1988

The Update Factor

Recommendation 1: Amount of the Update Factor for PPS Hospitals

For fiscal year 1988, the standardized amounts should be updated by the following factors.

- **An average 1.8 percent reduction to reflect first-year PPS cost information. This reduction entails separate adjustments for urban and rural hospitals of -1.9 and -1.1 percent, respectively;**
- **The projected increase in the hospital market basket (currently estimated at 4.9 percent);**
- **A discretionary adjustment factor of 0.5 percentage points composed of two allowances:**
  - **—A -0.8 percent allowance for scientific and technological advancement, productivity change, and site-of-care substitution; and**
  - **—A positive allowance for real case-mix change (currently estimated at 1.3 percent).**

In addition, the DRG weights should be adjusted to remove any increase in the average DRG weight occurring during fiscal year 1987.

This recommendation reflects the Commission's judgment about the appropriate increase in the level of PPS prices for fiscal year 1988. It assumes that the Commission's other concerns regarding the payment formula and the DRG weighting factors are also addressed in the fiscal year 1988 payment rates. Further, the recommendation is based on the premise that no net reductions or increases in average per-case payments to hospitals will be effected through measures other than the update factor.

The Commission's recommendation would result in an estimated 2.3 percent increase in the average level of PPS prices for fiscal year 1988. This represents an estimated increase of 2.2 percent for urban hospitals and 3.0 percent for rural hospitals. The recommendation includes a separate adjustment for urban and rural hospitals to account for different cost experiences reflected by the first-year PPS cost data.

The numerical amount of the Commission's update factor recommendation is likely to be modified as more current market basket forecasts and additional information regarding changes in hospital case mix become available. The table below summarizes the components of the Commission's update factor recommendation.

Current law requires that the fiscal year 1988 PPS prices increase by the market basket minus 2 percent. The changes suggested in this recommendation would therefore necessitate legislative action. In particular, legislative authority would be required to create separate update factors for urban and rural hospitals.

The rationale for this recommendation is presented in Recommendations 2 through 4 and accompanying discussions. In addition, Technical Appendix A contains background information and analysis on issues related to the update of PPS payments.

Estimated Increase in PPS Prices for Fiscal Year 1988 Under Commission Recommendations

Adjustment to level of standardized amounts*	
Urban	−1.9%
Rural	−1.1
Average adjustment to standardized amounts	**−1.8**
Fiscal year 1988 update factor	
Fiscal year 1988 market basket forecast	4.9
Correction for fiscal year 1987 forecast error	0.0
Components of discretionary adjustment factor	
Scientific and technological advancement	0.5
Productivity	−1.0
Site substitution	−0.3
Real case-mix change in fiscal year 1987	
DRG case-mix index	0.8
Within DRG patient complexity	0.5
Total discretionary adjustment factor	0.5
Estimated total change in case-mix index for fiscal year 1987 (DRG weights adjusted after recalibration)	−1.3
Subtotal: Update and case-mix adjustment	**4.1**
Total change in PPS prices	
Urban	2.2
Rural	3.0
Average total change in PPS prices	**2.3**

* A total adjustment averaging 5.4 percent to be made in three equal increments through fiscal year 1990.

Recommendation 2: Adjustment to the Level of Standardized Amounts

The update factor should include an adjustment to lower the standardized amounts an average of 5.4 percent, phased in over three years. The urban standardized amount should be reduced by 5.7 percent, and the rural amount by 3.3 percent. The reductions should be made in three equal increments averaging 1.8 percent, beginning in fiscal year 1988. The adjustments are based on the Commission's judgment about how information on average Medicare costs per case from the first year of PPS should be incorporated into the update factor.

In past reports, the Commission recommended that when cost data reflecting hospital experience under PPS became available, the standardized amounts should be recalculated. The results could be used as one piece of information considered in recommending an update factor amount. Alternatively, the standardized amounts could be rebased—that is, the recalculated amounts could be updated and substituted for the current published rates, which are based on 1981 cost data.

The Commission believes that even though PPS was designed to break the direct link between each hospital's costs and its Medicare payments, average payments should be reason-

ably related to costs. Decisions about the level of PPS prices have been based partly on judgments about the extent to which hospitals could increase productivity and lower their costs. Periodically reviewing more recent cost data is the best way to assess the accuracy of such judgments.

ProPAC staff has used first-year PPS Medicare Cost Report data to recalculate the standardized amounts. Costs per case from the first-year PPS cost reports were substituted for 1981 costs per case. The only difference between the current standardized amounts and the newly recalculated amounts is the difference between the 1981 costs per case updated to the first year of PPS and the actual first-year costs.

The results show that the recalculated fiscal year 1987 standardized amounts, on average, are 12.3 percent lower than the current standardized amounts. The recalculated national urban standardized amount is 13.0 percent, or about $385 lower than the current amount. The recalculated national rural standardized amount is 7.6 percent, or about $185 lower. The 12.3 percent figure weights the two amounts by the proportion of PPS payments they reflect.

This difference should not be interpreted as an error in predicting first-year PPS costs. The recalculated amounts reflect a full year of hospital experience under PPS, during which hospitals had new incentives to reduce costs. The original standardized amounts were not intended to be projections of what hospital costs would be under PPS; the level was determined by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) limits. Therefore, some differential between updated and actual costs was expected.

As the Commission has stated previously, a great deal of judgment is required in deciding how to use this information to set the appropriate level of PPS prices. In its deliberations, the Commission reviewed a variety of approaches, and considered reductions ranging from 3.4 to 8.0 percent. (Technical Appendix A contains background information and options considered in the Commission's deliberations.)

The table below summarizes the judgments made by the Commission in developing its recommended reduction. The Commission began with the estimated 12 percent average cost differential. Once the overall reduction was determined, separate urban and rural adjustments were derived. The rural and urban reductions are in the same proportions as the rural and urban standardized amount differentials (7.6 percent and 13.0 percent).

ProPAC Treatment of First-Year PPS Cost Differential

Total cost differential	12%
"Non-shareable" portion [a]	4
"Shareable" portion [b]	8
Adjustment components:	
"Non-shareable" portion of cost differential	4.0%
Medicare's half of "shareable" cost reductions	4.0
Subtotal appropriate average recuction	8.0
Reductions accounted for in previous updates [c]	−2.6
Total recommended average adjustment [d]	5.4
Urban adjustment	5.7
Rural adjustment	3.3

[a] The portion of the differential attributed to shifts in site of care, errors in projecting costs, changes in hospital accounting practices, and auditing of cost reports.

[b] Cost reductions attributed to increased hospital efficiency.

[c] Estimated difference between actual updates for fiscal years 1985 through 1987 and what updates would have been if applied to a lower base.

[d] Reduction to be phased in equally over three years.

In recommending an average 5.4 percent cumulative reduction to the standardized amounts, the Commission considered several factors. First was the extent to which hospitals should share in the gains from PPS. In its previous update factor recommendations, the Commission has argued that efficiency gains should be shared equally between the hospital industry and the Medicare program.

It is primarily because of the importance of sharing efficiency gains that the Commission opposes a strict rebasing—that is, adjusting the standardized amounts for the entire 12 percent differential. That approach would be inconsistent with the basic incentives of PPS. Although individual hospitals would always have an incentive to lower costs, their actions might be affected if the cost-reducing incentives were removed from the industry as a whole.

The entire cost difference should not be shared for the purposes of setting PPS prices, however. Some of the cost reductions, such as those resulting from shifts in the site of care, should not be shared with the hospital industry. For some patients, outpatient treatment is now substituted for part of an inpatient stay. This shift results in higher Medicare payments to hospitals or other providers for outpatient treatment. In its update factor recommendations, the Commission has taken the position that cost reductions due to shifts in the site of care should not be shared with the industry.

In the Commission's judgment, 4 percent of the 12 percent cost differential should not be shared with the hospital industry. This portion takes into account site-of-care substitution and other considerations. In addition to efficiency gains and site substitution, part of the 12 percent difference may have arisen from errors in projecting costs and changes in hospital accounting practices.

Some very small auditing effects might also be reflected in the 12 percent cost differential. The first-year data were audited for about one-fourth of the hospitals, while the 1981 data were completely unaudited. Historically, auditing has reduced operating costs by 3 to 4 percent. Comparison of audited and unaudited first-year reports for the same hospitals, however, show that operating costs were reduced by less than 0.5 percent as a result of auditing. The first-year cost report audit focused on capital costs, which may be why the auditing effect on operating costs was below the historical level.

The Commission's recommendation apportions the remaining 8 percent of the cost differential equally between Medicare and the hospital industry. The total reduction the Commission considers appropriate is therefore 8 percent: 4 percent that is not to be shared with the industry, and 4 percent that is Medicare's half of the efficiency gains. The Commission believes that part of Medicare's share should be returned to beneficiaries in the form of reduced cost sharing or expanded benefits. (In Recommendation 18, the Commission proposes a change in the level of inpatient hospital cost sharing.)

The Commission also considered the extent to which PPS payments have already been reduced as a result of hospitals' early PPS experience. Although the cost data were not available during previous update factor determinations, there were indications that hospitals had responded to PPS incentives—particularly by shortening length of stay—and were doing well financially. This general assessment was reflected in the relatively low update factors for fiscal years 1986 and 1987. In addition, most of the savings from the reduction in indirect teaching payments were removed from total PPS payments.

PPS standardized amounts were originally computed using cost information from 1981 Medicare Cost Reports updated to fiscal year 1984. For both fiscal years 1984 and 1985, the level of the standardized amounts was required to be set so that payments under PPS would be equal to payments under the TEFRA cost reimbursement limits. Since the first year, the PPS rates have been updated by 3.4 percent in fiscal year 1985 (reflecting the budget neutrality factor), 0.5 percent in fiscal year 1986, and 1.15 percent in fiscal year 1987.

The Commission used the following approach to estimate previous reductions in PPS update

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factors. Alternative update factors since the first year of PPS were estimated as the market basket forecasts less the estimated effects of coding improvements and site substitution. This resulted in a cumulative increase over the three updates of 7.7 percent compared with the 5.1 percent actually granted, or a difference of 2.6 percent.

This interpretation implies that if a substantially reduced cost base had been used to set prices in the first year of PPS, cumulative updates from fiscal year 1985 through fiscal year 1987 would have been 2.6 percent higher. This 2.6 percent is thus subtracted from the 8 percent reduction to arrive at the cumulative average total recommended reduction of 5.4 percent.

The Commission recommends phasing in this reduction over a three-year period, making the average reduction 1.8 percent annually through fiscal year 1990. The reductions would be one component of an overall update factor for these years. Since this recommendation would result in separate update factors for urban and rural hospitals, it would require statutory change.

The phase-in would adjust PPS prices gradually. Some hospitals could absorb the entire reduction relatively easily. But hospitals in more difficult financial situations might be forced to make changes that would adversely affect the quality of care provided to Medicare beneficiaries.

This recommendation represents an approach that has been the source of considerable misunderstanding. Reducing the standardized amounts based on first-year PPS cost data has been interpreted as a breach of the basic principles of PPS and as an attempt to regulate hospital revenue margins. The Commission's recommendation is neither.

The recommended reduction applies only to future PPS prices—not to gains previously earned by the hospital industry. A fundamental principle of PPS is that if a hospital's costs for treating Medicare patients is less than its PPS payment, the hospital keeps the entire difference. This principle is not violated by the Commission's use of cost information as one factor in recommending the level of future prices.

The Commission reviewed data on hospital revenue margins, but did not directly factor the information into the 5.4 percent figure. The Commission does not believe that PPS prices should be set to achieve a particular average revenue margin. If all other factors were unchanged, the adjustment to the standardized amounts would lower PPS margins. But hospitals would have an opportunity to increase revenue margins by further reducing costs.

The Commission continues to be concerned that recommendations like this one may have disparate effects across hospitals. An across-the-board adjustment may have a detrimental effect on some hospitals, while others could absorb a larger reduction. Despite a high overall first-year PPS margin of 14.8 percent, 10 percent of hospitals had PPS margins less than -5.0 percent. Another 10 percent had margins greater than 23.4 percent. The Commission will continue to recommend improvements in the PPS payment formula. It will also examine other factors that might cause financial difficulties to particular types of hospitals. (The Commission's analysis of first-year PPS hospital revenue margins is presented in *Medicare Prospective Payment and the American Health Care System: Report to the Congress*, February 1987.)

The timeliness and validity of the Medicare Cost Report data also concern the Commission. In Recommendation 6, the Commission outlines a specific type of sampling scheme that will improve the timeliness of Medicare Cost Report information. The Commission will examine questions about the validity of cost report data submitted during PPS years, since the information has no bearing on PPS operating payments. Despite these issues, the Commission believes it is important to continue to collect and analyze Medicare cost information. These data are valuable for a variety of purposes, including determining the appropriate level of PPS prices.

Recommendation 3: Allowance for Scientific and Technological Advancement and Productivity Goals, and Site-of-Care Substitution

For the fiscal year 1988 payment rates, the allowance in the Discretionary Adjustment Factor for scientific and technological advancement, productivity improvement, and substitution in the site of service from inpatient to out-of-hospital settings should be set at minus 0.8 percentage points.

In constructing the Discretionary Adjustment Factor (DAF), the Commission is concerned with identifying factors that produce a change in the average cost of a discharge and determining the effect of these changes on the standardized amounts. The specific factors considered are : (1) scientific and technological advancement, (2) hospital productivity improvement, (3) site-of-care substitution, and (4) real case-mix change. The Commission's DAF judgments reflect considerations outlined in the statute establishing PPS as well as other factors that ProPAC determines are important. Together with the market basket inflation factor and the adjustment to the standardized amounts, the DAF updates the payment rates from fiscal year 1987 to fiscal year 1988.

The Commission recognizes that many factors can affect the average cost per case, and that it is difficult to develop precise estimates for the effect of individual factors. The interdependency among the individual DAF allowances is evident. For example, it is difficult to discuss the scientific and technological advancement allowance of the DAF without referring to real case-mix changes. The individual DAF allowances represent broad guidelines, which help to explain the rationale for the Commission's judgment.

The Commission recommends a 0.8 percent reduction in the fiscal year 1988 update factor to accommodate scientific and technological advancement, productivity improvement, and site-of-care substitution. This compares with the 1.4 percent reduction in payment rates that ProPAC recommended for fiscal year 1987. The smaller reduction for fiscal year 1988 reflects, in part, the Commission's conclusion that there is less potential for productivity improvement and site-of-care substitution than last year. On the other hand, the Commission believes that the allowance for scientific and technological advancement can be slightly less than it was in fiscal year 1987.

Consistent with its treatment of quality and long-term cost-effectiveness in previous recommendations, the Commission considered these factors in setting the level of the DAF and in examining each of the DAF components. Adjustments for scientific and technological advancement, hospital productivity, and site-of-care substitution are discussed below. The adjustment for real case-mix change is addressed in Recommendation 4.

Scientific and Technological Advancement—The scientific and technological advancement allowance is a future-oriented policy target. It reflects the Commission's judgment of the financial requirements for hospitals to implement quality-enhancing, cost-effective, but cost-increasing health care technologies and treatment modalities.

As stated in previous reports, the Commission believes that advances resulting in greater hospital efficiency do not require a special allowance since they ultimately should result in lower hospital costs. The effects of cost-decreasing technologies are considered in the productivity target.

ProPAC began to develop its fiscal year 1988 scientific and technological advancement allowance by identifying major new technologies and treatment modalities that could substantially increase average Medicare costs per case. The Commission's estimates included the effects of substituting new for existing technologies. Based on ProPAC-sponsored analyses, the Commission concluded that the major cost-increasing technologies studied would add no more than $128 million to Medicare costs in fiscal year 1988. To accommodate these technologies, the standardized amounts would need to be increased by 0.3 percent.

The Commission recommends a 0.5 percentage point allowance for scientific and techno-

logical advancement, which is somewhat higher than if the allowance were based solely on the adoption of new technologies. These new technologies constitute only a portion of the amounts that might be appropriate for inclusion in this component. In particular, these estimates do not reflect future-oriented changes in practice patterns and diffusion of existing technologies that the Commission wishes to encourage.

The recommendation presumes that, during fiscal year 1988, hospitals will still be able to finance part of their expenditures for new technologies from productivity gains. ProPAC further presumes that Medicare capital payments will be sufficient to accommodate capital expenses associated with the implementation of cost-effective new technologies and treatments.

Hospital Productivity—The productivity allowance in the DAF is a future-oriented target. It reflects potential changes in both efficiency and productivity resulting from PPS incentives to reduce the number and cost of resources used to treat patients.

The Commission adopted the position that it is both desirable and appropriate to translate productivity gains into price reductions. These price reductions should be shared by the Medicare program, the Medicare beneficiaries, and the hospital industry. The Commission also adopted the position that the Medicare program should not subsidize decreases in productivity.

In developing the productivity allowance, the Commission has examined past productivity trends as a basis for establishing reasonable targets for the future. Last year, the Commission examined various indicators of productivity change. Among them were changes in average length of stay, ancillary service use, and hospital staffing. The Commission recommended a minus 1.5 percent offset in the DAF, which represented a portion of the productivity savings to be achieved by the industry and shared with the Medicare program during fiscal year 1987.

In preparation for this report, the Commission expanded its efforts to include an examination of various labor productivity measures. In general, Commission analyses indicated little improvement in labor productivity during the post-PPS period through 1986. At the same time, the number of services produced per discharge—a measure of intensity—was reduced. This trend appears to have reversed in 1986, the last year for which ProPAC has data.

The above trends should be interpreted cautiously since the data have not been adjusted for case-mix and practice pattern changes (except as the latter changes are related to increased outpatient activity). Nevertheless, the trends observed are relatively consistent for different measures of productivity. Therefore, the Commission believes they are a reasonably accurate reflection of hospital industry performance during the period under study.

Based on its examination of these historical trends, the Commission recommends a minus 1.0 percent productivity allowance for fiscal year 1988. This reflects a productivity goal of 2.0 percent that would be shared equally between the Medicare program and the hospital industry. This allowance is somewhat less than the minus 1.5 percent offset recommended for fiscal year 1987. The smaller offset reflects the Commission's concern that hospitals may be unable to increase their productivity substantially as the PPS system matures. If the 1986 intensity increases are an indicator of increased real case mix, there may be less opportunity for hospitals to achieve large productivity gains in the future.

On the other hand, the Commission believes it is appropriate to expect that hospitals can continue to achieve reasonable productivity gains during the coming year. Although productivity has not improved substantially during the post-PPS period, the rate of productivity decline has steadily slowed down. This relative improvement in productivity was simultaneous with the reduction in services per discharge described above. It may indicate that, at least during the first two years of PPS, hospitals placed more emphasis on cutting services than on producing each unit of service more efficiently.

Moreover, PPS operating margin data for the first year of prospective payment indicate that

hospitals may have felt less financial pressure during the early stages of PPS than originally assumed. Thus, they may have taken fewer measures to increase productivity than if they had been under greater financial pressure.

Therefore, the Commission concluded that it is appropriate to exert modest financial pressure on the hospital industry to encourage hospitals to focus more of their efforts on improving productivity.

Site-of-Care Substitution—This DAF allowance reflects changes in inpatient resources resulting from the provision of out-of-hospital services to patients who formerly received such services during the inpatient stay. The Commission believes that the Medicare program and Medicare beneficiaries may be overpaying for these services since the cost base used to calculate DRG payment rates includes the costs of services now being provided in other settings.

The allowance is not meant to reflect how the diversion of entire admissions to other settings affects average Medicare costs per case. The impact of this type of shift would be more appropriately considered under the real case-mix change adjustment. Instead, the allowance reflects the provision of services before and after hospitalization. These services formerly were provided during the beneficiary's inpatient stay.

Recalculation of the standardized amounts, using more recent cost data, partially adjusts for site-of-care substitution. However, the cost data used to recalculate the standardized amounts lags four years behind the year for which the prospective payment is set. Therefore, the Commission recommends that a negative adjustment be included in the DAF to reflect site-of-care substitution during fiscal year 1987.

Ideally, analyses of site-of-care substitution would include examination of the services a patient receives throughout an episode of illness. Currently, however, there are no data that trace the costs of an episode of illness for Medicare patients.

The Commission examined a variety of indicators of site-of-care substitution. Among them were: (1) trends in Medicare program expenditures by type of provider, (2) trends in the disposition status of patients at least 65 years old, and (3) trends in intensity of treatment provided in the inpatient setting before and after adjustments are made for hospital outpatient activity.

Based on its examination of historical data, the Commission believes that the extent of site-of-substitution has diminished during the past year. Therefore, its recommended adjustment for site-of-care substitution is slightly lower than last year's—minus 0.3 percentage points for fiscal year 1988 compared with minus 0.6 percentage points for fiscal year 1987.

The Commission recognizes that the potential for site-of-care substitution is likely to diminish further and may disappear in the next few years. Nevertheless, it believes that site-of-care substitution has occurred and should be reflected in an offset in the DAF. For background information supporting this recommendation, see Technical Appendix A.

Recommendation 4: Adjustments for Case-Mix Change

For fiscal year 1988, the update of PPS prices should be adjusted for three types of case-mix change in the following manner:

- **A positive allowance in the DAF of 0.5 percent for within-DRG case complexity change;**
- **A positive allowance in the DAF of 0.8 percent for across-DRG real case-mix change; and**
- **An across-the-board reduction in the DRG weights for increases in the case-mix index during fiscal year 1987, currently estimated to be 1.3 percent.**

The Commission believes that prospective payments to hospitals should reflect changes in the characteristics of patients and treatments, not changes in medical record coding practices. To distinguish real case-mix change from upcoding, the Commission separates case-mix change into three components. Within-DRG case complexity changes do not affect hospital payments, but they do change patient-care resource

requirements. In contrast, factors that affect the distribution of cases across DRGs will also affect payments. Across-DRG changes in patient characteristics affect both payments and resource requirements. Changes in coding practices, however, affect payments without changing patient-care requirements. (These components are explained in greater detail in Technical Appendix A.)

The Commission includes allowances for real case-mix change (the components that properly should be accompanied by changes in payments) as part of its Discretionary Adjustment Factor recommendation. To account for upcoding, the Commission recommends offsetting all expected change in case mix across DRGs by an appropriate percentage reduction in the DRG weights. The combined effect of these allowances is to allow payment increases to accompany real case-mix increases but to remove the effects of upcoding from the payment base.

Distinguishing between real case-mix change and upcoding has been a difficult technical problem for both HCFA and ProPAC. Current methods and future plans for ameliorating this problem are described elsewhere (see Recommendation 28, Chapter 3, and Technical Appendix A.) Based on preliminary evidence, however, the Commission believes that case-mix change is becoming less pronounced than in prior years. Accordingly, the Commission's recommendation incorporates declining allowances for case-mix change, even though these allowances are still significant in dollar terms.

In 1986, the Commission recommended a 0.7 percent positive allowance for within-DRG case complexity change. This allowance was based on long-term trend estimates calculated from data provided by the Commission on Professional and Hospital Activities. This year's recommendation of a 0.5 percent allowance reflects the Commission's belief that case-mix change is becoming less pronounced.

In its final rule for fiscal year 1987 PPS payments, HCFA estimated that the total increase in the case-mix index during fiscal 1986 would be 2.6 percent. Very little data are available for gauging the 1987 trend in case-mix index change. Available data for the end of fiscal year 1986 and for early fiscal year 1987, however, support the Commission's belief that the magnitude of case-mix change is diminishing.

Lacking specific evidence on declining case-mix index change, the Commission has attempted to project a trend based on case-mix change information from 1986 and prior years. Based on past evidence and the anticipated course of the case-mix trend, it is appropriate to halve the fiscal year 1986 estimated increase of 2.6 percent. Thus, the Commission recommends an across-the-board reduction of 1.3 percent in the DRG weights to allow for the expected increases in the case-mix index.

The final estimate required to arrive at the Commission's case-mix change recommendation is to separate the expected 1.3 percent increase into real and upcoding components. The Commission has formerly argued that, as the total amount of case-mix index change declines, the proportion of the total that reflects real changes in patient care requirements should increase. Accordingly, the Commission has divided the 1.3 percent into estimates of 0.8 percent real case-mix change and 0.5 percent upcoding. The 0.8 percent allowance for real case-mix change represents a decline from 1.3 percent presented in ProPAC's November 1986 report to the Congress, while the 0.5 percent allowance for upcoding represents a decline from 1.4 percent.

The net effect of all three components of case-mix change on PPS prices is zero. The Commission believes that recent trends in real case-mix change are approximately offset by changes due to upcoding.

These allowances are preliminary and may be modified with the availability of more current data and more thorough analysis. Along with other changes, the Commission will report any modifications in case-mix components of the update recommendation during the rulemaking period prior to the establishment of the fiscal year 1988 payment rates.

The Commission continues to believe that estimates of case-mix change ought to be based on more complete data and methods of estimation.

Even if the case-mix change phenomenon is becoming less important, there is reason to be concerned about the lack of knowledge concerning changes in practice patterns and medical record keeping. These changes may have been influenced by the incentives of PPS in ways that are not well understood. Consequently, the Commission remains committed to data development and research in this area; it urges the Secretary to initiate the study of case-mix change described in Recommendation 28.

Recommendation 5: Update Factor for Excluded Hospitals and Distinct-Part Units

For fiscal year 1988, a target rate of increase factor, separate from the PPS update factor, should be used to update payment rates for the group of psychiatric, rehabilitation, and long-term care hospitals and hospital distinct-part units excluded from PPS. The target rate of increase factor should reflect the projected increase in the hospital market basket for these hospitals, corrected for forecast errors, minus a 0.5 percentage point adjustment for productivity and scientific and technological advancement goals established for PPS hospitals.

For fiscal year 1988, the target rate of increase factor for pediatric hospitals and distinct-part units should reflect the projected increase in the hospital market basket for PPS hospitals, corrected for forecast error, minus a 0.5 percentage point adjustment for the productivity and scientific advancement goals established for PPS hospitals.

Based on currently projected inflation rates, the Commission estimates that this recommendation would result in a 4.4 percent target rate of increase for all excluded facilities. This estimate is subject to revision as more current forecasts of inflation become available.

The PPS statute created two broad classes of hospitals—those that would be paid on the basis of DRGs and those that would not. Excluded hospitals—psychiatric, rehabilitation, pediatric, and long-term care hospitals (hospitals with unusually long average lengths of stay)—continue under cost reimbursement rules, which limit reimbursement per discharge. Both the PPS standardized amounts and the reimbursement limits for excluded facilities are to be updated each year.

The types of patients seen and the treatments they receive vary significantly between PPS and excluded facilities. In this report, the Commission adopts the same approach used in its previous update recommendations for excluded facilities. That is, it recommends the development of separate update factors for pediatric hospitals and distinct-part units, and for the group of psychiatric, rehabilitation, and long-term care facilities excluded from PPS. In OBRA 1986, Congress provided the Secretary with clear authority to establish target rates of increase for excluded facilities separate from the PPS update factor.

The Commission's update factor recommendation for excluded facilities includes two allowances in addition to inflation: one for scientific and technological advancement, and another for productivity change. A summary of the components of the Commission's recommendations for excluded facilities appears in the table following this discussion.

Market Basket Inflation Factor—In previous reports, the Commission recommended using the PPS market basket inflation factor as part of the update factor for pediatric hospitals and distinct-part units. It also recommended calculating a separate inflation factor for the group of rehabilitation, psychiatric, and long-term care facilities. These recommendations were based on the observation that the labor share of expenses in the latter group of excluded facilities is substantially higher than in PPS hospitals. Children's hospitals, however, were shown to have a mix of labor and nonlabor expenses similar to PPS hospitals. The differences in the use of labor and nonlabor resources had a substantial impact on previous calculations of the hospital market basket inflation factor.

In contrast to previous market basket calculations, the current estimate of the fiscal year 1988 market basket inflation factor for PPS and excluded facilities is the same (4.9 percent). This may not be the case in the future. It is impor-

tant to continue to calculate separate market basket inflation factors so that future differences in inflationary pressures can be detected and appropriately reflected in the update factor. In addition, calculation of the individual inflation factors should be refined to account for differences in the skill mix of employees in PPS and excluded facilities.

Therefore, the Commission reaffirms its previous recommendations. It calls for establishment of a separate inflation factor for the group of rehabilitation, psychiatric, and long-term care facilities, and use of the PPS market basket inflation factor for children's hospitals.

Scientific and Technological Advancement—The scientific and technological advancement allowance is a future-oriented policy target. It reflects the Commission's judgment of the financial requirements for hospitals to implement cost-increasing but quality-enhancing technologies used to treat Medicare inpatients.

In developing this allowance, the Commission attempted to estimate the potential impact of newly introduced devices or treatments on Medicare costs by examining a select group of technologies. Identification of the technologies followed a similar process to that used for new technological advances in PPS hospitals.

A significant portion of the increase can be attributed to the adoption of new modalities of treatment to accommodate changes in case-mix. In part, such case-mix changes result from PPS incentives to refer more patients—and refer them earlier—to excluded facilities (e.g., development of geriatric psychiatric units and medical/surgical psychiatric units).

Based on its analyses, the Commission concluded that it is reasonable to incorporate the PPS allowance for scientific and technological advancement in the update factor for excluded facilities. To accommodate the response of excluded facilities to a changing patient case mix, the Commission has set the allowance slightly higher than if it had been based solely on the emergence of new technologies. Data on which to base an explicit case-mix adjustment for excluded facilities are insufficient. Until more specific measures of case-mix change are developed, the Commission believes that a slightly more generous scientific and technological advancement allowance is justified to accommodate treatment modality changes in response to changing case mix.

Productivity—The productivity allowance is a future-oriented target that reflects potential changes in both efficiency and productivity resulting from implementation of constrained target rate of increase limits.

In developing the allowance, the Commission examined past productivity trends as a basis for establishing a reasonable target for the future. For psychiatric, rehabilitation, and long-term care hospitals, hospital labor productivity substantially improved in the post-PPS period compared with the pre-PPS period. Using similar indicators, productivity in PPS hospitals was found to decline slightly during the post-PPS period.

Wide annual fluctuations in the excluded facilities' admissions limit any strong conclusions concerning productivity trends. Based on the data, the Commission believes that the productivity target for both excluded and PPS hospitals should be equally stringent.

Case-Mix and Site-of-Care Substitution Adjustments—The Commission reaffirms its previous recommendation that there should be no adjustments for case-mix change, real or otherwise, in the target rate of increase for excluded facilities. Excluded facilities are not paid on a DRG basis, and coding change does not influence their payments. Therefore, any PPS adjustment for coding change is inappropriate for these hospitals.

On the other hand, excluded hospitals may be experiencing increases in the medical care needs of patients due to earlier transfer of sicker patients from PPS hospitals. At this time, however, suitable data for estimating the degree of case-mix change in excluded facilities is unavailable. The Commission has attempted to partially account for some of this case-mix change in the scientific and technological advancement allowance.

The Commission continues to believe that there is insufficient justification for including a negative adjustment for site-of-care substitution in the excluded facility target rate of increase limit. Compared with PPS hospitals, excluded facilities have much weaker incentives and opportunities to shift services to other settings. As noted in the case-mix discussion, these facilities are more likely to receive transfers from other facilities than to discharge patients early and refer them elsewhere. Nevertheless, some preliminary evidence suggests that a greater emphasis on outpatient treatment may be leading to shorter stays and greater use of post-hospital outpatient services in psychiatric hospitals (site-of-care substitution). There is not enough evidence, however, on which to base a quantitative adjustment. Moreover, there is no similar evidence for rehabilitation facilities. For background information supporting this recommendation, see Technical Appendix A.

Estimated Increase in Excluded Hospital Payment Limits for Fiscal Year 1988 Under Commission Recommendations*

Fiscal year 1988 market basket forecast	4.9%
Correction for fiscal year 1987 forecast error	0.0
Discretionary adjustment factor	−0.5
Scientific and technological advancement	0.5
Productivity	−1.0
Total change	4.4

*Excluded hospitals are children's psychiatric, rehabilitation, and long-term care.

Recommendation 6: Timely Availability of Medicare Cost Report Data

Medicare Cost Report data should be routinely collected from a sample of PPS hospitals. The sample should be made up of PPS hospitals with accounting years that begin in the first four months of the Federal fiscal year. Data from this "early return" sample would provide more timely estimates of the costs of PPS hospitals. The Commission believes these data are necessary for assessing the relationship between PPS payments and hospital costs and for analyzing the costs of individual DRGs. The Commission will complete further analyses to determine how an early return sample should be developed for hospitals excluded from PPS but subject to the rate of increase limitations.

The Commission has previously identified the need for more timely hospital cost data for improving PPS and for assessing the effects of PPS on hospitals. In ProPAC's April 1986 report, the Commission encouraged the Secretary to consider alternative strategies for sampling cost report data. In addition, the Commission stated its intention to study the feasibility of developing a representative sample of PPS hospitals from a subset of hospitals with reporting periods beginning early in the Federal fiscal year.

There is a considerable lag in obtaining a complete set of cost reports. The lag results in part because most hospitals have accounting years that begin after the start of the Federal fiscal year. For example, the set of cost reports for the third year of PPS, which began in October 1986, will include hospitals with accounting years ending as late as August 1988. Hospitals have three months to submit the report. As a result, it takes up to 15 months after the end of the fiscal year to receive a full set of cost reports. Additional time would be necessary if the reports were to be audited. Time is then needed to enter the data into the automated data processing system. Thus, there is a time lag of approximately 18 months to two years from the end of the Federal fiscal year to the time the data can be analyzed.

Sampling PPS hospitals with accounting years beginning in the first four months of the fiscal year could provide a set of as-submitted (i.e., unaudited) cost reports at least eight months sooner than is currently possible. The Commission has completed its study of whether cost data received early (an "early return" sample) in the fiscal year can be used to estimate the cost characteristics of PPS hospitals as a whole.

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ProPAC sponsored an analysis of the representativeness of the PPS hospitals with accounting years that begin during the first four months of the Federal fiscal year. Empirical weights were developed to make the sample representative of the full set of PPS hospitals. It was found that the weighted sample differed very little from the overall set of hospitals. Hospital characteristics as well as capital and operating cost variables were included in the comparison. The study also found that the statistical precision of the sample in estimating costs appears to be very close to that of the full set of hospitals. (More detail on the study is included in Technical Appendix A.)

This study has shown that empirical weights could be developed for the sample to produce precise and representative cost estimates for PPS hospitals. Thus, the Commission believes that developing a sample of PPS hospitals with early reporting periods is methodologically feasible. The Commission welcomes the opportunity to work with HCFA to develop such a sample.

The Commission recognizes that collecting and processing these data to develop usable analytic files would require additional resources. Cost data from the first year of PPS has been extremely valuable to the Commission in understanding the financial effects of PPS and in developing recommendations for this report. Nonetheless, because the recommendations apply to the fifth year of PPS while the data are from the first year, the timeliness of the data has become a concern. Therefore, the Commission believes that the importance of these data warrants additional allocation of resources for routinely collecting and processing cost data for a sample of hospitals.

The Commission believes that a similar sample should be developed for hospitals excluded from PPS but subject to the rate of increase limitation. Information from these cost reports could be used to determine the appropriate update for the rate of increase limitation for these hospitals.

The Commission has completed a preliminary review of the first-year PPS cost report data for the excluded hospitals. Only 27 percent of the excluded hospitals have accounting years that begin in the first four months of the fiscal year. This compares with 55 percent for PPS hospitals. Thus, it is not clear that the same early return sampling scheme recommended for PPS hospitals is appropriate for excluded hospitals. The Commission will complete further analyses to determine how to develop such a sample for these hospitals.

Capital

Recommendation 7: All-Inclusive Rate

The Secretary should initiate a transition to a new capital payment method beginning in fiscal year 1988. This method should combine operating and capital cost components in a single prospective payment per case.

This recommendation is a reaffirmation of a recommendation ProPAC made in its April 1986 report. The Commission continues to be convinced that retrospective cost-based reimbursement for capital introduces distorted incentives for investment decision making that need to be corrected as soon as possible.

The existing capital cost pass-through fails to encourage hospitals to evaluate interest rates or alternative financing methods in planning or investment decisions. This payment mechanism has led some hospitals to undertake capital expansion projects that may exceed the needs of the population served, thereby resulting in excess capacity. The capital cost pass-through provides incentives for hospitals to inappropriately substitute capital for labor or other operating costs.

The Commission believes that the Medicare capital payment system should provide hospital managers with flexibility to implement the most cost-effective decisions based on their institution's unique characteristics. While cost pass-through payment limits reduce Medicare outlays, this method still fails to provide hospitals with appropriate incentives to change their investment behavior. For this reason, the Commission recommends that an all-inclusive payment rate, combining operating and capital cost

components in a single per-case payment, should be implemented beginning in Federal fiscal year 1988.

During the discussion of capital payment methods, the Commission considered arguments against recommending the all-inclusive rate approach. It was pointed out that this method of payment would represent an unprecedented departure from current reimbursement practices, which link payment amounts to hospital investment cycles. In addition, some Commissioners were concerned that a flat payment system would be insensitive to community need and therefore potentially wasteful. Despite these concerns, however, the Commission decided that the advantages of an all-inclusive rate outweigh the disadvantages.

Furthermore, the Commission continues to maintain that the capital payment method adopted should distinguish between fixed capital (buildings and fixed equipment) and moveable capital (moveable equipment). The method should recognize differences in the nature of fixed and moveable capital expenditures and the incentives influencing hospital decisions for these components.

Finally, the Commission is concerned about the effects of recent tax reform legislation (Pub. L. 99-514) on hospitals during the transition to prospective capital payments. This legislation contains a provision that limits the number of times a hospital can refund an existing tax-exempt bond issue. Limitations on the number of refundings may impair some hospitals' ability to reduce their capital-related costs. This impairment may, in turn, contribute to hospital financial vulnerability under new Medicare capital payment policy. The Commission will monitor the effects of this legislation as it considers alternative financing mechanisms available to reduce vulnerability for certain hospitals during the capital payment transition period. (For more information on tax reform changes, see Technical Appendix A.)

In its deliberations leading to the reaffirmation of the all-inclusive rate, the Commission considered grandfathering capital costs. The proposal was advanced by members of the hospital industry and is under consideration by the Congress. After reviewing the proposal, the Commission concluded that its phase-in approach is a more equitable and appropriate way to bring capital payment into PPS.

Based on analysis conducted by ProPAC staff, the Commission concluded that those hospitals that grandfathering was intended to protect (i.e., hospitals with recent major capital expenditures) are reasonably protected under a capital payment transition plan similar to that proposed by the Commission. Furthermore, the magnitude of individual hospital gains and losses relative to actual cash needs is far greater under grandfathering than under a more traditional capital payment approach as recommended by ProPAC. Finally, the grandfathering approach poses potential serious financial hardship for hospitals that need to build in the near future, yet miss the grandfathering deadline. Therefore, the Commission rejected the grandfathering approach and adopted the capital payment plan outlined in the following recommendations. (For a description of the analysis, see Technical Appendix A.)

Recommendation 8: Level of Federal Capital Payment

Capital payments should be added to the Federal portion of PPS payments for hospital cost reporting years beginning in fiscal year 1988 at a spending level consistent with that established by the Omnibus Budget Reconciliation Act of 1986.

The level for fiscal years 1988 and 1989 should be based on official Medicare inpatient capital spending projections in fiscal year 1987. The projections should include all capital components as presently determined on a reasonable cost basis.

The Omnibus Budget Reconciliation Act of 1986 requires the Secretary to reduce the amounts for capital-related payments to PPS hospitals (determined on a reasonable cost basis) by 3.5 percent, 7 percent, and 10 percent for portions of cost-reporting periods occurring in Federal fiscal years 1987 through 1989, respectively. OBRA 1986 recognizes that the Secretary

has the authority to incorporate capital payments into the prospective payment system or to continue payments on a reasonable cost basis. However, the Secretary may choose to incorporate capital into PPS by regulations. If this occurs, Medicare aggregate payment amounts for capital under the new system must be the same as they would have been if they were determined on a reasonable cost basis subject to the above reductions. Sole Community Hospitals are exempt from the reductions specified above. Furthermore, if the Secretary implements, by regulation, a new system for capital payment, Sole Community Hospitals would be exempt from the new system for the first three years.

The Commission recognizes that the Congress may limit capital payments in the future. In addition, the Secretary may constrain the increase in capital expenditures after Federal fiscal year 1989, when the reductions required by OBRA 1986 expire.

The Secretary should project actual inpatient capital spending levels under cost-based reimbursement for Federal fiscal years 1988 and 1989 based on the best data available in Federal fiscal year 1987. The spending reductions required under OBRA 1986 should be taken from these projections. The Commission believes that this approach would prevent hospitals from being penalized if they respond positively to the incentives of a new capital payment system.

Furthermore, the Commission believes that, in establishing the payment level for Federal fiscal years 1988 and 1989, the Secretary should not apply all the spending reductions required by OBRA 1986 to the Federal portion of the capital payment amount. Such reductions should not disproportionately affect one capital component more than another.

As hospital capital payments become more dependent on the Federal portion, financial problems could arise. The Commission believes that the hospital-specific and Federal payments, and the fixed and moveable portions of these payments, should be reduced equitably. This would provide appropriate incentives for hospitals to reduce overall capital spending levels, while affording them an opportunity to adjust their behavior. The Commission is concerned that the Secretary may apply all the spending reductions required by OBRA 1986 to the Federal portion of the capital payment amount. If this happens, the Federal portion could be severely constrained in the later years of the transition. This could lead to a Federal payment amount that is lower than may otherwise be desirable.

The Commission recognizes that in attempting to be in accordance with OBRA 1986 while moving toward a new method of capital payment, desired long-term savings may not be attained immediately. It is more important that hospitals be afforded a smooth transition and an opportunity to adjust their behavior without major financial disruption.

The Commission intends to closely monitor the appropriateness of the level of Federal capital payments during Federal fiscal years 1988 and 1989, and encourages the Secretary to do likewise. Information obtained during this period will help determine what capital payment limits, if any, should be imposed after Federal fiscal year 1989.

Recommendation 9: Capital Payment Transition

The transition to Federal capital payments under PPS should begin in fiscal year 1988 in the following manner.

- **Payments for fixed capital should be phased in over a ten-year period on a straight-line basis.**
- **Payments for moveable capital should be phased in over a three-year period on a straight-line basis.**
- **Hospital-specific fixed and moveable capital payment portions should be based on the actual capital costs incurred during each year of the transition.**

The Commission reiterates its belief that hospitals need a transition period to help them absorb the financial impact of a new Medicare capital payment system and to adjust their spending behavior accordingly. Further, the Commission believes that during this transition

period hospital-specific payments should be based on actual capital costs. This will assist hospitals in meeting their debt obligations and encourage cost-effective capital decision making in the future.

The Commission continues to believe that the transition for fixed capital should be relatively long. The capital payment system should allow for the long-term nature of fixed capital expenditures and the need for hospitals to meet financial commitments obligated prior to the beginning of PPS.

In the April 1986 report to the Secretary, the Commission recommended a seven- to ten-year transition for fixed capital. Since that time, the Commission has conducted additional analyses comparing these two transition options. The Commission concluded that a ten-year transition provided more financial protection to a broader group of hospitals. Additional analysis indicated that a ten-year transition provided adequate protection from significant financial hardship. (See Technical Appendix A.) Hence, the Commission has revised its recommendation accordingly to include a ten-year transition for fixed capital. During the transition, the hospital-specific payment share would decline by approximately 10 percent a year, and the Federal payment share would increase by approximately 10 percent a year.

After considering information provided by representatives of the health care industry, the Commission also reexamined its position regarding a transition for moveable capital expenses. The Commission concluded that a transition for moveable capital would allow hospitals greater flexibility and reduced financial risk while moving to prospective payments for moveable capital.

Consequently, the Commission decided to incorporate a three-year transition for moveable capital into its capital payment recommendation. The hospital-specific payment share would decline by approximately 33 percent a year, and the Federal payment share would increase by approximately 33 percent a year.

The Commission reiterates its position that movement to an all-inclusive payment under PPS is its primary objective in developing a capital payment policy. The transition mechanism incorporated in such policy should ensure that most hospitals can meet their long-term capital commitments while providing incentives to make cost-effective capital decisions for the future.

Recommendation 10: Institutional Neutrality

Until the start of the transition to an all-inclusive PPS payment rate, the Secretary should provide supplemental payments to hospitals for capital costs incurred at other facilities. These costs are not currently reimbursed by Medicare.

Capital payment policy under PPS should allow for fair payment of capital-related expenses associated with providing services to Medicare patients, regardless of the site of care. Inpatients may receive services at a facility other than the hospital that receives the DRG payment. Currently, Medicare does not pay the capital-related costs of providing these services. Thus, hospitals have an incentive to provide all services in-house, even if this is not the most efficient use of resources.

When a hospital contracts with another facility to provide patient services, the hospital is billed by the other facility for operating and capital-related costs. However, the capital-related costs are not used in the calculation of the hospital's capital pass-through payment. (See Technical Appendix A.)

Supplemental payments for these capital costs should be made until the start of a transition to an all-inclusive payment rate. Under an all-inclusive rate, hospitals would receive a payment reflecting the total costs (i.e., both operating and capital costs) of all services provided, regardless of the delivery site. Hospital managers would have an incentive to select the most cost-effective method and site of treatment for Medicare inpatients.

The Secretary also should consider the extent to which this problem affects hospitals that are exempt from PPS. The payment incentives

described previously also apply to exempt hospitals, because their operating costs are subject to the rate of increase limits.

Recommendation 11: Capital Exceptions Process

> **The Secretary should develop an exceptions policy to assist hospitals that are vulnerable to financial hardship when capital payment is included under PPS. Hospital eligibility criteria should emphasize the goal of ensuring continued access of Medicare beneficiaries to high-quality hospital services. The exceptions policy should not be used to protect hospitals simply because they are in financial difficulty. Therefore, a limited dollar pool should be made available with strict criteria to be used in determining which hospitals would be eligible for a capital payment adjustment.**

The Commission believes that, while its proposed capital payment system is adequate for the vast majority of hospitals, some hospitals may experience financial hardship as a result of new policy. During the past year, ProPAC sponsored the development of a capital investment model and conducted analysis to estimate the magnitude and distribution of hospitals that are vulnerable as a direct result of new capital payment policy.

Analysis results indicate that few hospitals appear to be vulnerable as a result of the inclusion of capital into PPS. (See Technical Appendix A.) Furthermore, capital vulnerability appears to be evenly distributed across hospital classes as currently defined for Medicare payment purposes. Analysis results also indicate that ProPAC's capital payment plan provides appropriate incentives for hospitals to evaluate overall financial condition and capacity utilization and to adjust their capital spending behavior accordingly.

Nevertheless, the Commission is concerned that quality and accessibility of care for Medicare beneficiaries may be jeopardized by the vulnerability of some hospitals to financial hardship when capital payment is included under PPS. Therefore, the Commission recommends that an exceptions policy be adopted to address the financial needs of these institutions.

The transition to an all-inclusive rate, as the Commission has recommended, should not be contingent on the development of an exceptions policy. Most capital-vulnerable hospitals would not experience financial shortfalls during the early years of the transition to ProPAC's capital payment system. The Commission believes that, during this period, capital payments are sufficient to meet the hospital's cash needs. Even so, the Secretary should develop an exceptions process as soon as possible. This process will enable hospitals to better plan future capital investments and assist those that will become capital vulnerable in later years.

The exceptions policy should not focus on a single class of hospitals. Instead, its should consider hospital financial condition and beneficiary access in determining eligibility and appropriate remedies. Furthermore, the exceptions process should be budget neutral, deriving funds from aggregate capital payments for hospitals.

The Commission will continue to study the issue of capital vulnerability in an effort to assist the Secretary in developing an exceptions policy. Efforts will focus on better understanding the nature, distribution, and factors influencing capital vulnerability. The Commission also plans to examine financing mechanisms that may assist capital-vulnerable hospitals during periods of financial difficulty.

Adjustments to the Payment Formula

Recommendation 12: Improving the Definition of Hospital Labor Market Areas

> **The Secretary should adopt improved definitions of hospital labor market areas.**
>
> - **For urban areas, the Secretary should modify the current Metropolitan Statistical Areas to distinguish between central and outlying areas. The central area should be defined using urbanized areas as designated by the Census Bureau.**

- **For rural areas, the Secretary should distinguish between urbanized rural counties and other rural counties within each state. Urbanized rural counties should be defined as counties with a city or town having a population of 25,000 or greater.**

The implementation of improved definitions should not result in any change in aggregate hospital payments. Furthermore, these definitions should not affect the assignment of hospitals to urban or rural areas for purposes of determining standardized amounts.

In its April 1985 report, the Commission recommended that the Secretary improve the definition of hospital labor market areas to better account for wage variation within urban and rural areas. This recommendation was supported by evidence of substantial wage variation between inner-city and suburban hospitals within several large Metropolitan Statistical Areas (MSAs). The Commission expressed concern that substantial wage variation might also be found within rural areas. During 1985, the Commission initiated a major study to determine methods for improving labor market area definitions. In its April 1986 report, ProPAC reiterated its previous recommendation and called for the Secretary to adopt improvements no later than fiscal year 1988.

The Commission continues to believe that improvements in the definition of labor market areas are necessary to increase the equity of hospital payments. Under PPS, hospital payments are adjusted using the area wage index to reflect area differences in the cost of labor. This index is defined as the ratio of the average wage within a labor market area to the national average wage for all labor market areas.

For fiscal year 1987, there are 365 labor market areas consisting of 317 urban areas and 48 rural areas. Urban labor markets are designated according to MSAs as defined by the Executive Office of Management and Budget. Rural labor markets are designated as all remaining counties within a state that are not included within an MSA.

ProPAC's study of hospital wages, which is described in Technical Appendix A, confirms the Commission's belief that large wage variations occur within the current labor market areas. Moreover, evidence from this study indicates that improved definitions are necessary for both urban and rural labor market areas. The Commission believes that the most practical method for improving these definitions is to identify additional labor markets within the current area definitions. This method would not change the current boundaries between urban and rural areas.

The Commission believes that the greatest improvement in urban areas can be achieved by dividing MSAs into urbanized and nonurbanized areas. Hospitals within urbanized areas, on average, have wages almost 16 percent higher than hospitals in nonurbanized areas. Urbanized areas within an MSA are defined by the Census Bureau based on census tracts that contain a population density of 1,000 per square mile or greater. Urbanized area designations are updated after each census. About 84 percent of all urban hospitals are located in urbanized areas.

For rural areas, the Commission believes that the greatest improvement can be achieved by dividing rural counties within each state into urbanized and other counties. The average hospital wage within urbanized rural counties is about 8.5 percent higher than the average wage within nonurbanized counties. About 8 percent of all rural hospitals are located in urbanized rural counties.

The Commission's recommendation, if implemented, would raise the number of labor market areas from 365 to 563. The Commission believes that the administrative cost associated with this change is far outweighed by the associated increase in the equity of hospital payments.

The Commission recognizes that the Secretary does not have the authority to reassign counties to MSAs or to alter MSA designations. This recommendation, however, does not require the Secretary to change any of the current urban/rural boundaries. Furthermore, the Commission

believes that the Secretary has the authority, under Section 1886(d)(3)(E) of the Social Security Act, to implement the improvements proposed in this recommendation.

Recommendation 13: Improving the Area Wage Index

The Secretary should update the hospital wage data necessary for calculating the area wage index on a regular basis. This updated information should include data on the wages and hours of employment for hospital occupational categories.

Because of the importance of the area wage adjustment, the Commission believes that the HCFA survey of hospital wages should be updated on a regular basis to reflect changes in the relative cost of hospital labor in different labor market areas.

During the first two years of the prospective payment system, the wage index was based on a national survey of hospital wages and employment maintained by the Bureau of Labor Statistics (BLS). The BLS survey contained several important technical limitations, however, that affected the accuracy of the area wage index. One important limitation was that the survey did not distinguish between part-time and full-time employees. As a result, the BLS wage index underestimated the cost of labor in areas that employ an above-average share of part-time workers.

To address this limitation, HCFA conducted its own survey of wages in hospitals subject to the prospective payment system. This survey measures the total hours of employment in each hospital rather than the total number of employees. This change permits a more accurate measurement of the impact of part-time employees on average area wages. Beginning May 1, 1986, the Secretary implemented a revised wage index based on the HCFA wage survey. In fiscal year 1987, the wage index is also based on this survey, with minor changes to reflect the reassignment of several rural counties to urban areas.

The HCFA wage survey, however, is based on data from hospital fiscal years that ended in calendar year 1982. This was prior to the implementation of the prospective payment system, which has had a dramatic impact on hospitals and their staffing patterns. The Commission believes, therefore, that the HCFA survey should be updated on a regular basis to reflect changes in the relative costliness of hospital labor.

Another important limitation of the HCFA survey-based wage index is that it does not account for variations in hospital occupational mix. Variations in occupational mix may be related to factors such as hospital case mix and teaching activity that are already accounted for in hospital payments. Hospitals in areas that employ an above-average mix of occupational skills, therefore, may be overcompensated for their higher labor costs.

Findings from the ProPAC-sponsored study of hospital wages suggests that occupational mix does have an impact on hospital wages. The magnitude of this impact, however, is difficult to determine because the available data for measuring hours of employment and wages among different occupational categories are very limited. The Commission believes, therefore, that these data should be collected as part of a regular update of the hospital wage survey. The data could then be analyzed to determine whether an adjustment to the area wage index is warranted to account for the impact of occupational mix.

Recommendation 14: Extension of Volume Protection to All Isolated, Rural Hospitals

The Secretary should seek legislation to expand the eligibility for a PPS volume adjustment to all isolated, rural hospitals that meet the criteria for Sole Community Hospital status. Eligibility should not be limited to those that have obtained such status in order to maintain 75 percent hospital-specific payments.

Current legislation grants the Secretary the authority to adjust payments to Sole Community Hospitals that incur volume declines of 5 percent or more due to circumstances beyond the hospital's control. This authority expires on October 1, 1988.

The SCH adjustment was established at the time routine per-diem cost limits were imposed under Section 223 of the 1972 Social Security Amendments and thus predates PPS. The provision was adopted to protect beneficiaries from additional charges that the hospital could legally bill under the legislation. It was also intended to help ensure that such patients would not be turned away from facilities because of insufficient Medicare payments. If no reasonable alternative existed for hospital care, it was argued that the burden of the additional charges or denial of care would fall heavily on the elderly.

The concern for beneficiary access also underlies the continuation of the SCH exception under PPS. In this case, the concern relates to the impact of hospital insolvency on Medicare beneficiary access to care. Hospitals that become insolvent cannot continue to provide care to anyone. In isolated areas with single hospital providers, hospital closure would likely force area residents to travel long distances to receive care. While this might not be unduly burdensome for the general population, it could create a significant barrier to care for Medicare beneficiaries.

HCFA has specified that to qualify as a Sole Community Hospital under PPS, a hospital must meet one of the following conditions:

- It must be located more than 50 miles from a similar hospital.
- It must be located between 25 and 50 miles from a similar hospital and meet one of the following criteria:
  - — The hospital must be the exclusive provider to at least 75 percent of the service population, or to at least 75 percent of the Medicare beneficiaries in its area, or
  - — The hospital must have fewer than 50 beds; further, the Peer Review Organization or intermediary must certify that the hospital failed to meet the exclusive provider criteria because specialty services were unavailable, forcing beneficiaries to seek care outside the area, or
  - — The hospital must be isolated from similar hospitals for at least one month a year due to local topography or prolonged periods of severe weather.
- It must be located between 15 and 25 miles from a similar hospital and be isolated for at least one month a year due to local topography or severe weather conditions.

Currently, 363 hospitals are designated SCHs. There are a few urban SCHs; the majority are small, rural facilities. All rural hospitals that qualify for SCH status do not, however, apply for it. The precise number of hospitals that would otherwise qualify for SCH status is unknown. For these hospitals, the financial advantages of the national PPS rate may outweigh the financial protections afforded by SCH status.

The SCH provision attempts to protect isolated hospitals from insolvency in three ways. First, payment is based on a combination of 75 percent hospital-specific and 25 percent Federal rates. Second, there is a three-year exemption of Sole Community Hospitals from capital payment cuts and from capital prospective payment if such hospitals were so classified before October 1, 1990. Third, payment is adjusted for a decline in discharges of more than 5 percent over the preceding cost period, if the decline is due to factors beyond the hospital's control.

The volume adjustment is recalculated annually. A hospital must experience a volume decline each year of greater than 5 percent. The adjustment is calculated based on a careful evaluation of the fixed and semifixed costs incurred during the period in which the volume decline occurred. Based on this evaluation, an adjustment is made for the fixed and semifixed costs not covered under cost-based reimbursement for capital costs.

To qualify for a volume adjustment, a hospital must accept continuation of payment that is based on 75 percent of its own historical (gener-

ally 1982) costs. This provision was designed to protect hospitals whose cost per case was higher than the national rural average. In effect, this provision constituted a potential subsidy to hospitals that met the criteria for SCH status.

Recent HCFA studies show, however, that per-case costs among a significant number of SCHs are below the national average. ProPAC analyses also indicate that per-case costs for a significant proportion of small rural hospitals (those with fewer than 50 beds) are lower than the national average. Consequently, some hospitals experiencing large declines in volume face a dilemma. They must choose between higher national payment to help defray revenue loss caused by declining volume, or lower payment—but potentially greater protection from this phenomenon—afforded by SCH status.

If the goal of the volume protection provision is to protect isolated hospitals from financial risk due to volume declines outside their control, the Commission believes it should be extended to all hospitals that might be so classified under the SCH criteria. Under these circumstances, an isolated hospital that has demonstrated financial vulnerability due to volume declines beyond its control would be eligible for a volume adjustment but still could receive the national rate.

This recommendation could be regarded as a way to subsidize isolated hospitals. But the original SCH provision has already provided subsidies to a subgroup of isolated hospitals to maintain stand-by capacity in areas with less than average demand for hospital services. In effect, the Commission's recommendation would expand protection to a greater proportion of Medicare beneficiaries whose access to health care is provided by isolated hospitals. For more information on this recommendation, see Technical Appendix A.

Recommendation 15: Clarification of Sole Community Hospital Volume Exception Criteria

Before fiscal year 1988 begins, the Secretary should issue instructions for implementing the Sole Community Hospital volume adjustment that clarify the interpretation of the criteria used to grant such an adjustment. The application process for a volume adjustment should be simplified.

Currently, hospitals that meet the criteria for Sole Community Hospital status and experience more than a 5 percent decrease in their total discharges for inpatients in the preceding cost reporting period are eligible for a volume payment adjustment. The Health Care Financing Administration has issued regulations outlining the criteria and procedures to be followed in granting this adjustment (42 CFR Part 412.92; 50 Fed. Reg. pp. 491-492, March 29, 1985). To qualify, a SCH must: (1) submit documentation to the intermediary demonstrating the size of the decrease, (2) show the impact on per-case costs, and (3) show that the decrease is due to extraordinary circumstances beyond the hospital's control, including (but not limited to) strikes, fires, floods, earthquakes, inability to recruit essential physician staff, or unusually prolonged severe weather conditions.

HCFA determines on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment. This adjustment is based on: (1) a determination of whether the above qualifications have been met, and (2) an assessment of the reasonable cost of maintaining necessary hospital staff and services and the hospital's fixed and semifixed costs not reimbursed on a reasonable cost basis.

According to recent HCFA data, only 11 of the approximately 363 SCHs have applied for a volume adjustment since the beginning of PPS. Of these hospitals, seven have been denied a volume adjustment: four because the hospital continued to experience profits despite the decline, and three because extraordinary circumstances had not been demonstrated. In two of the latter three cases, the hospitals claimed that local economic problems had caused precipitous volume declines. HCFA has viewed such circumstances as insufficient, in and of themselves, to justify a volume adjustment.

Given the large average volume declines observed in small rural hospitals since 1984, the lack of applications for a volume adjustment is

surprising. In part, the small number of applications may reflect uncertainty by both providers and intermediaries about what constitutes "extraordinary circumstances." For example, what evidence is required to demonstrate the inability to recruit essential physician staff? Under what circumstances could a hospital demonstrate that local economic circumstances have significantly reduced the demand for hospital services? Generally, clarification of regulations is provided in implementation instructions to the intermediaries. These instructions have not yet been issued.

Implementing instructions that clarify volume adjustment qualifying criteria would provide a basis for both hospitals and intermediaries to determine the reasonableness of the currently applied criteria. Furthermore, such instructions might facilitate implementation of a simplified adjustment process. Instructions could be developed that would permit granting an automatic adjustment if certain criteria were met. This process would allow the hospitals to determine whether developing the necessary information to apply for an adjustment would be worth the effort. It would also provide intermediaries with uniform guidelines on which to base their advice to hospitals. For more information on this recommendation, see Technical Appendix A.

Recommendation 16: Evaluation of Current PPS Payment Policies for Rural Hospitals

The Secretary should complete the studies mandated by Congress in the original PPS and deficit reduction legislation and make them publicly available as soon as possible.

- **The study on the feasibility and impact of eliminating or phasing out separate urban and rural DRG prospective payment rates should reflect analyses based on first-year PPS Medicare Cost Reports and, if possible, preliminary findings from the second year of PPS.**

- **The study of Sole Community Hospitals should be supplemented by an evaluation of the appropriateness of current Medicare payment policies for all small, isolated rural hospitals.**

The Commission also intends to examine these issues and will share its findings with the Congress and the Secretary as they are developed.

In the Social Security Act amendments of 1983 and the Deficit Reduction Act of 1985, Congress required the Secretary to study and report on a number of issues related to rural hospitals. None of the reports have been submitted to Congress. Preliminary analyses of recent data suggest that there continue to be potential inequities in the treatment of rural hospitals under PPS. Medicare payment policies need to be thoroughly evaluated to ensure that they do not inadvertently place rural hospitals at a disadvantage and jeopardize access to hospital care for Medicare beneficiaries. In particular, the Commission believes that the different levels of urban and rural DRG payments and the Sole Community Hospital provisions warrant a thorough evaluation. Specific issues to be evaluated are outlined below.

Maintenance of Separate Urban and Rural DRG Payments—The current PPS payment policy to calculate separate urban and rural standardized amounts reflects the historically lower average costs of rural hospitals found in 1981. These cost differences remained even after adjusting for area wage differences, teaching activity, and DRG case mix.

The cost differences were partly attributed to the wider range of services offered by urban hospitals, and to differences in the severity of illness the DRG case-mix index did not reflect. Despite these explanations, however, the cause of these differences has never been fully determined.

Whatever the cause of the cost differences, the establishment of separate standardized amounts has resulted in lower payments to rural hospitals. Because of recent legislation, which created separate outlier pools and discharge weighting, the differential in the standardized amounts will be reduced from approximately 25 percent to approximately 17 percent.

Recent analyses by ProPAC, HCFA, and the Congressional Budget Office (CBO) indicate that, between 1981 and the first year of PPS, costs

per case rose more rapidly in rural compared to urban hospitals, especially after adjusting for changes in case mix. If the standardized amounts were computed using the first-year PPS cost data, ProPAC estimates the differential in the urban and rural standardized amounts would be reduced to 13 percent.

Narrowing of the payment differential between urban and rural hospitals has resulted as a by-product of changes in PPS payment policies in different areas. Under the Commission's proposed update factor recommendation, the differential between the urban and rural standardized amounts would be reduced after three years to 14 percent. The Commission believes it is time to evaluate the wisdom of continuing separate urban and rural payments and the appropriateness of further reducing the differences in payment rates.

Sole Community Hospitals and Small, Isolated Rural Hospitals—The Medicare program, as a result of the recent OBRA 1986 legislation, has made a variety of adjustments in PPS to accommodate the problems of rural hospitals, including special payment provisions for SCHs. The extent to which these provisions provide adequate financial protection against financial risk beyond the control of small, isolated rural hospitals is unclear, however.

The Commission is not suggesting that Medicare policies guarantee the solvency of all rural hospitals or even all small rural hospitals. Rather its concern is to ensure that Medicare policies do not jeopardize access to quality hospital services for Medicare beneficiaries living in isolated rural areas.

In its April 1986 report, the Commission expressed concern that volume and case-mix fluctuations in small, rural hospitals might seriously jeopardize their financial viability and, consequently, access to hospital services for Medicare beneficiaries living in these areas. The Commission noted that minor fluctuations in volume and case mix are less critical for larger hospitals since they can average the fluctuations from year to year and over many cases. Small rural hospitals cannot take advantage of this "law of large numbers."

The Commission continues to be concerned that small, isolated rural hospitals are at major financial risk due to volume declines. Much of the volume decline can be traced to general economic declines in rural areas and to general reductions in the demand for inpatient care affecting all urban and rural hospitals. While volume declines have occurred across all classes of hospitals, they have been greatest for small rural hospitals.

According to American Hospital Association (AHA) data, rural hospitals with fewer than 25 beds and those with 25 to 50 beds experienced decreases in average daily census of 28 percent and 14 percent, respectively, between 1980 and 1984. This compared with a 6 percent reduction for all U.S. hospitals. In 1984, rural hospitals with fewer than 25 beds had an average daily census of 7 patients, whereas hospitals with 25 to 49 beds averaged 16 patients per day. AHA Annual Survey data for all small hospitals (80 percent of which are estimated to be rural) indicate a further decline in volume between 1984 and 1985. During this period, admissions per hospital declined 7.6 percent for community hospitals with fewer than 50 beds compared with a 4 percent decline for all U.S. community hospitals.

These volume declines have a potentially devastating effect on small rural hospitals because they tend to operate closer to the margin. This effect becomes even more significant in isolated areas with only a single hospital, where opportunities for gaining financial stability through consolidation are precluded.

Data on the financial status of small, isolated rural hospitals are unavailable. Nevertheless, available data on hospitals with fewer than 50 beds provide insight into the vulnerability of these hospitals. According to recent data from the AHA Panel Survey, average net patient revenue margins for hospitals with fewer than 50 beds were negative in the first six months of 1986 (-11.0 percent for hospitals with fewer than 25 beds and -1.8 percent for hospitals with 25 to 49 beds).

While not strictly comparable to the analyses described above, recent ProPAC analyses of

first-year PPS Medicare Cost Report data indicate that rural hospitals with fewer than 50 beds have the lowest Medicare PPS median margins of any class of hospital (7.0 percent compared with 11.6 percent for all hospitals). Rural hospitals with fewer than 50 beds were the only group of hospitals to have negative median patient margins (-3.7 percent) from all payers during the first year of PPS. Moreover, rural hospitals with fewer than 50 beds comprised over 41 percent of all hospitals whose PPS deficits exceed 5 percent.

Recent simulation analyses by the Congressional Budget Office indicate that the financial vulnerability of a substantial portion of small rural hospitals will continue under a fully implemented PPS. According to these analyses, 30 percent of rural hospitals with fewer than 50 beds are estimated to incur a per-case PPS deficit in 1987.

These data suggest that small rural hospitals may continue to experience substantial financial difficulties under PPS. To ensure appropriate evaluation of the effect of PPS on Medicare beneficiaries' access to care, it will be important to monitor the PPS effect on all isolated rural hospitals, not just those electing to be SCHs. Currently, there is no well accepted definition of a small, isolated rural hospital. Nor are there data to identify the universe of isolated rural hospitals. While information on SCHs is available, these hospitals represent only the subset of isolated hospitals that have elected SCH status. The Secretary should develop information on hospitals that would otherwise meet the qualifications of a SCH but which, for various reasons, including financial, have chosen not to seek SCH status.

This discussion highlights two major areas of concern the Commission has addressed during the past year. While the congressionally mandated studies may not cover the complete range of issues outlined by the Commission, they are likely to provide valuable baseline information on which to build a more thorough evaluation. The Commission, therefore, urges the Secretary to complete and publish the findings from these studies as soon as possible. The Commission will also continue to analyze these issues and would welcome the opportunity to work cooperatively with the Secretary in these efforts. The Commission would be particularly interested in developing an ongoing data base to evaluate the effect of PPS on small, isolated rural facilities. For more background on rural hospital issues, see Technical Appendix A.

Recommendation 17: Improvements in Outlier Payment Policy

> **The Secretary should continue to review outlier payment policy and implement refinements to reflect more accurately the resources hospitals use to treat outlier cases. The Commission is concerned that outlier payments may not adequately protect hospitals from the risk of extremely costly cases. Identifying risk at both the case level and the hospital level should be incorporated into any consideration of policy change. The Commission encourages current research that examines outlier discharges at the hospital, DRG, and case level. The Commission intends to continue its own examination of outliers and will share the results with the Secretary and Congress.**

Outlier payments are additional compensation for Medicare cases that have atypically long lengths of stay or unusually high costs, as determined by specific threshold criteria. The additional payments help to defray some of the losses incurred by hospitals due to random occurrence of outlier cases. The Commission is concerned that the regulatory criteria for determining payment may not result in equitable payment, given hospital use of resources.

Outlier policy was also created to account for inherent limitations in case-mix measurement. When comparing the level of case-mix index (CMI) with the proportion of outlier payments by hospital group, hospitals with high CMIs experienced the largest percent of outlier payments. Although this pattern is anticipated, it remains unclear whether the payments are adequate.

Hospitals with a larger proportion of outlier cases may be seeing the sickest patients. Therefore, these hospitals may be unfairly treated

even if they receive a greater share of outlier payments. On the other hand, the law of large numbers might not protect hospitals with small numbers of discharges, so that small hospitals may be hurt financially by only a few outlier cases. Most importantly, the Commission is concerned that beneficiaries who are likely to become outliers may suffer problems of access or quality if outlier payment policy issues are not addressed.

Outlier analyses completed by ProPAC suggest an uneven distribution of outlier payments and discharges by hospital group and by DRG. Results of hospital-level analyses indicate that outlier payments average 4.2 percent of total payments across hospitals, but vary from 1.1 percent to 9.5 percent across hospital groups. When comparing outlier and inlier cases, the concentration of cases on a DRG-level is different. For example, the set of DRGs accounting for 50 percent of outliers does not overlap extensively with the set of DRGs accounting for 50 percent of the inliers.

Analysis also included an examination of "dual outliers," those cases that meet both length of stay and cost outlier criteria. The data suggest that dual outliers have considerably higher total charges and longer lengths of stay than other outlier types. While dual outliers represent approximately 25 percent of all outlier cases, they account for nearly half of total outlier charges. A summary of ProPAC's outlier analysis appears in Technical Appendix B.

Because of the distributional differences suggesting that outliers are not randomly distributed across hospitals, the Commission believes that further research is needed to determine the appropriateness of current outlier policy. The Commission is aware of the HCFA and Congressional Research Service research efforts and supports their work. ProPAC outlier analysis is also continuing.

Beneficiary Concerns

Recommendation 18: Inpatient Hospital Cost-Sharing Requirements

The proportion of inpatient hospital payments borne by Medicare beneficiaries should be returned to its pre-PPS level. This proportion has inappropriately increased as a result of significant declines in length of stay experienced since the beginning of PPS. Furthermore, the structure of inpatient hospital cost-sharing requirements should be consistent with PPS incentives. In particular, current coinsurance and spell of illness requirements need to be reexamined.

Cost sharing borne by Medicare beneficiaries has inadvertently increased as a result of PPS. The inpatient hospital deductible and daily coinsurance rates rose substantially as a result of declines in length of stay that are largely attributed to PPS incentives. In addition, the shift of some services from inpatient hospital treatment to the outpatient setting may have increased beneficiary out-of-pocket costs.

The Commission believes that beneficiaries should share in the gains from PPS along with hospitals and the Medicare program. In its 1986 report, ProPAC recommended changing the formula used for computing Medicare's inpatient hospital deductible. Under the recommended change, the share of hospital payments borne by beneficiaries would remain constant at the pre-PPS level.

Although the Congress legislated a change in the formula that will limit future increases, beneficiaries are still paying a higher proportion of inpatient hospital payments per case than before PPS. In 1983, beneficiary deductibles and coinsurance accounted for about 8.0 percent of payments to hospitals for inpatient services. Under current law, the proportion for 1987 is 9.2 percent.

The deductible should be reduced to reflect the pre-PPS proportion. Under current estimates, the adjustment would reduce the current deductible to $445. This reduction should be financed by the Medicare program, since it cor-

rects the inadvertent increase in the deductible that occurred before the formula was changed. It should apply to all admissions in both PPS and excluded facilities.

PPS has also affected coinsurance payments. Since the daily coinsurance rate is tied directly to the deductible, this amount has also increased directly as a result of PPS, from $89 per day in 1984 to $130 per day in 1987 for days 61 through 90. After 90 days during a benefit period, patients may draw from a lifetime reserve of 60 days. Coinsurance on these days is 50 percent of the deductible, or $260 per day in 1987. After using up their lifetime reserve days, patients no longer receive Medicare coverage for inpatient care during the benefit period.

In addition, coinsurance for Medicare skilled nursing facility (SNF) services has been affected. The coinsurance requirement begins after 20 days, and is set at one-eighth of the inpatient hospital deductible, or $65 in 1987. Due to the PPS-related increases in the deductible, the SNF coinsurance amount may exceed the average daily Medicare SNF reimbursement in some parts of the country.

Some beneficiaries may be responsible for a large portion of the hospital payment under current cost-sharing requirements. For example, daily coinsurance requirements can exceed the PPS outlier payment to the hospital for the same day. This is most likely to occur for length of stay outlier cases treated in certain low-weighted DRGs, particularly in rural areas. The coinsurance amount can exceed the day outlier payment because the hospital payment is based on PPS payment rates, separate from the deductible. The beneficiary liability must not exceed the total owed the hospital for the entire stay, but the liability is not so limited on a daily basis.

Since coinsurance is required beginning on the 60th inpatient day during a benefit period, only the sickest patients or those living in institutions bear this burden. This requirement, along with the lifetime reserve days requirement, was established prior to PPS. At that time, there may have been a need to provide incentives to limit lengths of stay. Current PPS incentives for hospitals to limit length of stay are sufficient to prevent them from providing unnecessarily long stays.

The spell of illness concept should also be reconsidered. A Medicare Part A benefit period begins with the first day of hospitalization and ends when the individual has not been a patient in an institution for 60 consecutive days. Consequently, some beneficiaries who are institutionalized never have a break in the spell of illness, and eventually exhaust their inpatient hospital benefits.

With no other changes to the cost-sharing structure, eliminating the spell of illness would increase beneficiary liability. Due to the spell of illness rules, about 30 percent of admissions fall within a benefit period, and the beneficiary is not liable for the deductible. If the spell of illness rules were revoked, and there were no other changes in cost sharing, beneficiaries as a group would pay more deductibles, but less coinsurance. Other changes in cost sharing could be combined with eliminating spell of illness requirements so that aggregate beneficiary liability was not increased.

Although some of the circumstances described above are rare, they can result in significant cost-sharing requirements to the beneficiaries affected. Most beneficiaries have private Medigap insurance that will cover the Medicare cost sharing, but beneficiaries or employer-sponsored pension plans must pay premiums for this coverage. In addition, about 20 percent of beneficiaries have neither private coverage nor Medicaid. Moreover, beneficiaries should not have to rely on coverage by other payers to compensate for problems with Medicare's cost-sharing structure.

Current legislative proposals would restructure inpatient hospital cost-sharing requirements as part of a broader change to Medicare benefits. Discussion of these proposals should address the inadvertent increases in inpatient hospital cost-sharing requirements since PPS and the appropriate structure of cost-sharing requirements in light of PPS incentives. Background information on beneficiary liability issues is included in Technical Appendix A.

Recommendation 19: Evaluating the Results of PRO Quality of Care Review

The Secretary should promptly initiate a comprehensive evaluation of PRO quality of care review activities and findings. The evaluation should assess the impact on quality of care of preadmission, admission, transfer, and readmission review activities. The PRO findings concerning quality of the services furnished during an admission and the health outcome of the episode of care should also be evaluated. The Commission is aware that the SuperPRO is auditing and validating PRO review activities. This effort, however, does not substitute for a comprehensive evaluation of the extent to which PROs are identifying, assessing, and correcting problems related to quality of care.

The Medicare prospective payment system contains financial incentives for hospitals to improve efficiency and productivity in the delivery of high-quality care. There has been concern, since PPS was implemented, that these incentives could reduce the quality of care furnished to Medicare beneficiaries. In addition, many longstanding concerns about quality of care that predate PPS still require attention.

Recognizing these concerns, the Congress required that hospitals sign agreements with PROs to assess and review utilization and quality of care. HCFA has contracted with the PROs to provide a wide range of administrative, utilization review, and quality review functions.

The Commission continues to be concerned by reports of possible declines in the quality of care that Medicare beneficiaries receive. To study these reports, ProPAC recommends a comprehensive, national evaluation of the extent to which PROs are engaged in quality of care review, as opposed to other activities like utilization review and DRG validation. A study of PRO quality of care review will also provide valuable information concerning the quality of care currently being furnished to Medicare beneficiaries. It will further serve as a base line for future assessments.

The evaluation study should examine the quality aspects of all the major PRO review activities. It should include the techniques PROs use as well as the guidelines and standards governing their efforts. In addition, the study should examine the results of outpatient surgery and other cases for which the PRO has denied payment on preadmission review. The quality of care received by patients who have been transferred or readmitted, and the quality of services rendered during an admission, should also be evaluated.

As the Commission recommended in its April 1986 report, the focus of PRO quality of care review should be on the entire episode of care. The evaluation should include, in addition to the period of hospitalization, an assessment of the quality of care (and outcome) related to the overall episode of illness.

The Commission does not believe that the activities of the SuperPRO meet the intention of this recommendation. The SuperPRO is principally concerned with the validation of medical determinations made by the PROs. The SuperPRO is directed to report on quality issues that arise during its sample review process. But it is not required to evaluate quality of care problems that have been identified or the actions taken to correct them. The SuperPRO also does not evaluate the PRO's commitment to quality of care review as opposed to utilization review.

Concerns regarding the quality of care received by Medicare beneficiaries are likely to continue. The PROs are in a unique position to assess the quality of care individual patients receive. The Commission strongly urges the Secretary to promptly initiate a major evaluation study to assess the results of PRO quality of care activities.

Patient Classification and Case Mix

Recommendation 20: Improving the Measurement of Hospital Case Mix

The Commission continues to believe that the DRG system is the most appropriate measure of hospital case mix for the Medicare PPS. The Secretary, however, should

improve the measurement of case mix to better account for variation in resource use. In the short-term, the Secretary should adopt refinements to the DRG system that make better use of currently available patient data. In the long-term, it may be necessary to develop improvements based on additional sources of patient information not currently available from the discharge abstract.

In its April 1986 report, the Commission stated that the DRG system was the most appropriate of the available measures of hospital case mix for PPS. In addition, the Commission stated that it was undertaking a systematic evaluation of the DRG system. One goal of this study was to identify potential problems in DRG construction and classification. A second goal was to develop improvements in the DRG system, using currently available patient information, to better account for resource use and to increase the equity of hospital payments.

Based on the findings from its systematic evaluation of the DRG system, the Commission believes that modest but important improvements are possible within many DRGs. The Commission also has completed several separate studies of improvements to the DRG system that support this conclusion. These include eliminating the use of patient age (Recommendation 21), refining the list of complications and comorbidities (Recommendation 22), and updating the surgical hierarchies and the list of operating room procedures (Recommendation 23). Furthermore, the Commission believes there is no conclusive evidence to justify replacing the DRG system with an alternative patient classification system based on currently available patient data.

In the short-term, the Commission urges the Secretary to adopt these recommendations to refine the DRGs. The Commission also believes that modifications to outliers as defined by current policy may account for variations in resource use that cannot be accurately accounted for by the DRG system (Recommendation 17).

In the long-term, the Commission believes that improvements in the measurement of case mix may require additional patient information not currently available from the discharge abstract. This conclusion is supported by several studies being conducted by HCFA and others. These studies are evaluating modifications to the DRG system and alternative systems for measuring case mix that require additional patient information.

The Commission believes that a long-term approach is necessary because many DRG modifications and alternative case-mix systems that use additional patient information are still being developed and refined. The Commission has concluded, therefore, that it is premature to recommend modification of the DRG system to include additional patient information until these modifications and alternative systems are more completely developed. Furthermore, the Commission believes that studies will be needed to determine the impact of replacing the DRG system with an alternative case-mix system that uses additional patient information. For more information on this recommendation, see Technical Appendix B.

Recommendation 21: The Use of Patient Age in Defining DRGs

DRGs should not be defined based on the current variable of age greater than 69 and/or presence of a complication or comorbidity (CC). The Commission believes that the resource use for Medicare patients 70 years or older without a CC is significantly lower than for cases with CCs. DRGs should be defined on the basis of the presence or absence of a CC, regardless of age. The Secretary should implement this change for DRGs that currently split on age and CC, and should determine whether other DRGs should also be split on CC.

Patient age is currently used to define 190 DRGs that distinguish patients who are under 70 from those who are 70 or older. Patient age is typically used in combination with the presence of a CC to form two groups: patients with "age > 69 and/or CC" and patients with "age < 70 without CC."

The age and/or CC variable was included in the assignment criteria for the DRGs based on

evidence of resource use. Patients 70 years and older had been found to have similar patterns of resource use, measured by hospital length of stay (LOS), that are similar to those with CCs. Therefore, separate DRGs were defined for patients who were at least 70 years old or who had a CC. The data used in the development of DRGs, however, included all patients, not just the Medicare population. The Commission became concerned after reviewing preliminary evidence suggesting that this relationship may not hold for the Medicare population.

The Commission analyzed charges from the 1984 PATBILL file to determine if this relationship holds for Medicare patients. The study examined the relative effects of the presence of CCs and beneficiary age 70 years or more on total charges. The objective of the analysis was to determine the appropriateness of the current age and/or CC combination variable used in defining the DRGs. In addition, this analysis examined the extent to which the presence of a CC alone, regardless of age, explains differences in charges among cases.

The study confirmed that LOS and charges are significantly higher for the patients with "age > 69 and/or CC," but that the presence of a CC is the critical factor. In fact, the data indicated that, in all but a few cases, grouping patients who are over 69 with the CC patients is inappropriate. The average LOS and charges for patients who are over 69 without a CC are more similar to patients without a CC than to patients with a CC. Overall, the average charges for patients who are over 69 without a CC, while only 4 percent higher than the other non-CC patients, are 30 percent lower than changes for all patients with a CC.

Thus, while both advanced age and the presence of a CC clearly are associated with higher resource use, the effect of having a CC is much greater. In terms of charges, it would be better to distinguish between patients if the DRGs were defined on the basis of having a CC, regardless of age. These findings hold for both medical and surgical DRGs, but are especially dramatic for the surgical DRGs.

Based on these analyses, the Commission believes that, in classifying patients according to resource use, the current combination variable (age and/or CC) appears to be less powerful than the presence of a CC alone. Further, in almost all cases, defining DRGs based only on the presence of CCs is more appropriate in grouping Medicare cases for payment purposes under PPS. The Commission cautions other users of DRGs that these findings are based on an analysis of the Medicare population. The conclusions drawn here may not apply to other groups.

Thus, the Commission encourages the Secretary to implement this change to the assignment criteria as soon as possible. These changes, in conjunction with a recalibration, will result in more accurate DRG weights. The Secretary should also study the DRGs that are not currently defined on the basis of age and/or CC to determine if splitting on the basis of CC is appropriate in some cases.

The Commission recognizes that these changes, if implemented, would give hospitals increased incentives to report the presence of CCs. This will improve the measurement of case mix to the extent that increased reporting of CCs reflects more accurate coding. The Commission will monitor increases in case mix that may result from this recommendation. For more information on this recommendation, see Technical Appendix B.

Recommendation 22: Improving the Use of Complications and Comorbidities in Defining DRGs

> **The Secretary should revise the current list of complications and comorbidities, and its use in defining DRGs, to ensure more appropriate grouping of Medicare cases for payment under PPS. The Secretary should evaluate several possible approaches, including the development of Major Diagnostic Category (MDC)- or DRG-specific CCs on the basis of resource intensity, and the specification of levels of complexity among the CCs.**

In both the April 1985 and 1986 reports, the Commission stated its intention to continue

studying classification problems for specific DRGs and groups of DRGs. ProPAC has completed several analyses that provide evidence of variation in case complexity within DRGs. Some of this variation can be linked to inadequacies in the assignment criteria of the DRG system.

The list of complications and comorbidities was identified as one area for evaluation. The Commission undertook several studies to evaluate the CC variable in DRG classification. One of these studies tested a clinical methodology to refine the CC list for two Major Diagnostic Categories (circulatory and respiratory). As a result of this pilot study, the Commission believes that modification of the CC variable will improve DRG classification.

The pilot study demonstrated that the current list of CCs can be modified to distinguish levels of complexity among the diagnoses. This modification can help to explain variation in resource use among the DRGs.

ProPAC's study also evaluated the cumulative effect of multiple CCs. Several methods of aggregating multiple CCs were found to better account for variations in resource use. Currently the DRGs do not reflect the resources required to treat specific CCs or combinations of CCs. The Commission believes that additional research to further evaluate the use of multiple secondary diagnoses should continue. This will help to better describe differences in case complexity within DRGs and explain variation in resource use.

The methodology used in this pilot project was primarily clinical. ProPAC believes that major efforts to revise the CC list and its use for DRG classification can be further enhanced by including a combined clinical and statistical process.

The Commission is aware that HCFA has several projects under way to develop and evaluate modifications to the CC list and to the DRGs. The Commission encourages the Secretary to expedite these efforts, utilizing the findings of ProPAC's study. For more information on this recommendation, see Technical Appendix B.

Recommendation 23: Updating the Surgical Hierarchies and the List of Operating Room Procedures

The Secretary should evaluate the surgical hierarchies periodically. They should be updated to determine both the clinical appropriateness and resource intensity of the procedures within each class and the relative order of the modified surgical classes. This assessment is necessary to ensure that the hierarchies accurately reflect the relative resource intensity of each operating room procedure. This update process should include clinical input from a broad range of clinicians, including physicians, operating room nurses, medical record experts, and other health care professionals.

In its 1985 and 1986 reports to the Secretary, the Commission indicated the need to review the list of operating room (OR) procedures and surgical hierarchies. Further, the Commission noted several inconsistencies in DRG assignment when multiple procedures are performed.

The DRG system uses OR procedures for grouping patients. Operating room procedures within each Major Diagnostic Category are assigned to a surgical hierarchy. This hierarchy reflects the intensity of resource use for each OR procedure, as determined by clinical judgment. A patient with multiple procedures is assigned to a surgical DRG based on the most resource intensive OR procedure in that hierarchy.

ProPAC recently completed a pilot study that analyzed the current hierarchies in three target MDCs (Diseases and Disorders of the Digestive System [6]; Kidney and Urinary Tract [11]; and Male Reproductive System [12]). The findings support the need for a reexamination of the present classes and hierarchies. They also suggest performing further evaluation on a system-wide basis. These modifications should be incorporated into the Grouper.

Since the implementation of PPS, HCFA has made several changes to the surgical hierarchies. The Commission believes this should be continued on a regular, more consistent basis. To increase the success of future

modifications, an iterative approach should be used. It should combine clinical input with empirical data about the resource intensity of procedures. This approach is consistent with the methodology adopted by the developers of the DRG system.

Use of the most recent Medicare discharge data and the clinical input of health care professionals, who also have an in-depth knowledge of the DRG system, would produce surgical procedure groupings more reflective of today's technology and costs. For more information on this recommendation, see Technical Appendix B.

Recommendation 24: Improving Grouper Logic and ICD-9-CM Coding

The Secretary should develop and implement changes to ICD-9-CM and the use of these codes by the DRG Grouper. Specifically, the Secretary should evaluate how the Grouper recognizes ICD-9-CM guidelines and make revisions where necessary to ensure more accurate DRG assignment. More consistent coding guidelines should be developed for the selection of principal diagnosis and sequencing of other diagnoses. Further, noted deficiencies in the ICD-9-CM coding system should be addressed in the next revision (ICD-10). Finally, the Secretary should review all the codes in Chapter 16 of the coding system to establish consistent coding rules and guidelines and help ensure more appropriate DRG assignment.

In its April 1986 report, the Commission recommended several improvements regarding ICD-9-CM coding and its use in the DRG system. For example, the Commission previously recommended the use of new codes to describe new or changing technologies or practices, such as pacemakers. ProPAC has also recommended the implementation of administrative mechanisms to identify specific procedures or conditions when a new code cannot be developed in a timely manner. The Commission is concerned that many of these issues remain unresolved.

During the past year, the Commission has continued to identify problems related to ICD-9-CM coding. Four generic issues related to ICD-9-CM coding rules and their effect on DRG assignment have been identified. The issues are:

- Grouper logic regarding ICD-9-CM coding rules and guidelines in determining DRG assignment,
- Sequencing of diagnoses,
- Use of Chapter 16 diagnoses as principal diagnosis, and
- Use of multiple codes and combination codes.

The first issue relates to the specific use of ICD-9-CM codes and conventions by the Medicare program. The last three issues relate to longstanding coding rules for all applications of ICD-9-CM. The Commission believes that, in many cases, inconsistencies and discrepancies in coding rules and guidelines appear to be causing problems in determining appropriate DRG assignment and payment. The Secretary should evaluate these inconsistencies and discrepancies and their effect on equitable hospital payments.

There are many explicit coding rules and guidelines for ICD-9-CM. Sometimes the rules are implicit, incomplete, inconsistent or vague, frequently resulting in subjective interpretations in the coding process. The Secretary should provide explicit clarification when this occurs.

DRG assignment is highly dependent on the identification and coding of the principal diagnosis. Thus, the sequencing of all reported diagnoses has a major effect on DRG assignment. In most instances, specific definitions, rules, and guidelines are used to make these decisions. But in many instances the rules and guidelines are unclear or absent.

ICD-9-CM is a dual classification system allowing classification of both disease etiology and manifestation. This creates additional sequencing problems in coding underlying disease processes and manifestations or complications. In most cases there are not specific rules regarding the sequencing of etiology and manifestation.

Inappropriate DRG assignments also result because the Grouper does not consider all diagnoses regardless of their reported sequence. Further, ICD-9-CM guidelines specify when multiple codes are required to describe a single, distinct clinical entity. The failure of the Grouper to classify patients using multiple codes may limit the ability of the DRGs to classify patients accurately. Alternative classification systems, such as Patient Management Categories and Disease Staging, do not have these DRG Grouper deficiencies.

Chapter 16 of the ICD-9-CM system contains a catchall of symptoms, signs, and ill-defined conditions as well as abnormal findings of laboratory or other investigative procedures. Other signs and symptoms that indicate a more definitive diagnosis are assigned to the appropriate category elsewhere in the ICD-9-CM system. The Commission believes that the guidelines prohibiting the use of codes from Chapter 16 to describe the principal diagnosis should be reviewed. This rule, which is open to wide interpretation, has caused the DRG assignment problem for patients with chronic obstructive pulmonary disease who are admitted in respiratory failure.

The Commission believes that the current restriction governing the use of Chapter 16 codes seems to contradict other guidelines governing the use of manifestation and etiology sequencing. Apparently, for example, because the ICD-9-CM code for dehydration appears in Chapter 3, Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders, rather than in Chapter 16, the coding rule is different for dehydration and gastroenteritis than for conditions appearing in Chapter 16.

Generally, ICD-9-CM encourages the use of several codes to fully identify a particular condition or a procedure. Multiple coding may be mandatory. It is also used if there is no combination code, and several codes are necessary to identify fully all components of a patient's condition. While the rules for multiple coding are usually clear, there are inconsistencies throughout the ICD-9-CM system. The Commission believes that these inconsistencies sometimes cause inappropriate DRG assignment.

The Commission believes that a more critical aspect of these issues involves the DRG assignment process. The Grouper does not consider that multiple problems may be equally responsible for a patient's admission or that a diagnosis may require more than one code to describe the condition fully. In cases where the selection of the principal diagnosis is ambiguous or necessitates two or more codes for adequate description of the patient's condition, it appears inappropriate for DRG assignment to differ depending on the sequence selected.

The Commission has identified several potential problems as a result of the Grouper's failure to recognize coding conventions. First, the patient may be assigned to one MDC based solely on the principal diagnosis. As previously noted, however, the rules for selection of principal diagnosis are at times vague and unclear. In these cases, the terminology or semantics the physician uses to describe the condition, and the code determination the coder uses, can result in grouping clinically similar patients into different MDCs. Second, DRGs may be heterogeneous when patients have multiple diagnoses. The ambiguities in coding rules combined with Grouper logic may also create opportunities for subjective coding. The Secretary should review the specificity of coding rules and how the Grouper's failure to recognize those rules affects DRG assignment.

The Commission has identified other areas for further evaluation and plans to continue to study these issues. This analysis is likely to include: (1) an evaluation of the extent to which revisions to the DRGs should explicitly consider the use of multiple codes to describe one disease entity, and (2) whether more explicit and consistent rules for multiple coding should be developed. For more information on this recommendation, see Technical Appendix B.

DRG Classification and Weighting Factors

Recommendation 25: Temporary DRG for the Implantable Defibrillator

Implantable defibrillator cases should be assigned to a new, temporary, device-specific DRG.

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The implantable defibrillator is a relatively new medical device, used in the treatment of some life-threatening ventricular arrhythmias. Currently, implantable defibrillator cases are assigned to DRG 104 (cardiac valve procedures with pump and with cardiac catheterization).

The Commission believes that implantable defibrillator cases should be assigned to a new device-specific DRG because they are clinically distinct. Further, their resource needs differ from other cases in DRG 104. Assignment to a device-specific DRG would result in a weight that more accurately reflects the actual costs of using the device. It would also create more neutral financial incentives for the device's diffusion and use.

Because the implantable defibrillator is a new and changing technology, assignment of cases to a temporary DRG would allow making appropriate changes in the DRG weight until there is more experience with the technology. It is the Commission's intention to reevaluate these cases for permanent DRG assignment within three years of the implementation of this recommendation. For further information on this recommendation, see Technical Appendix B.

Recommendation 26: Temporary DRG for the Cochlear Implant

Cochlear implant cases should be assigned to a temporary, device-specific DRG.

The cochlear implant is a prosthetic device that can increase the hearing ability of certain profoundly deaf individuals. Discharges involving the implantation of this device have been assigned to DRG 49 (major head and neck procedures). The Commission believes that the classification of cochlear implant cases into DRG 49 is inappropriate, in terms of both resource consumption and clinical coherence.

The resource use associated with cochlear implant cases is different from the resource use for other cases in DRG 49. The payment hospitals receive under DRG 49 will not reflect the costs of implanting the multi-channel device and therefore will be inadequate for most cochlear implant cases. Conversely, the payment received under DRG 49 would overcompensate hospitals implanting a single-channel device.

The Commission is aware that grouping single- and multi-channel cochlear implants in a single new DRG would overpay for the costs of the single-channel device and underpay for the costs of the multi-channel device. ProPAC estimates, however, that 90 percent of the devices implanted will be multi-channel. Further, there are clear medical indications for each device. It is unlikely that the financial incentives that would result from grouping the devices in a single DRG would affect selecting the most appropriate device for an individual patient.

Clinically, the diagnoses and procedures for cochlear implantation are unlike those for other discharges in DRG 49. DRG 49 contains many long length of stay and labor-intensive procedures. Cochlear implant cases, however, require a very short length of stay, and are not labor-intensive.

The Commission is aware that the cochlear implant is a new and developing technology. Assigning cochlear implant cases to a new, temporary DRG would allow HCFA and ProPAC to better evaluate the costs of cochlear implants and payments to hospitals. The Commission will reevaluate this procedure for permanent DRG assignment within three years of the implementation of this recommendation. For more information on this recommendation, see Technical Appendix B.

Recommendation 27: Additional Payment for Magnetic Resonance Imaging Scans

For a three-year period, Medicare should pay hospitals an additional amount (called an add-on) to reflect operating costs for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a PPS hospital. The add-on payment should be calculated by the Secretary each year to reflect both changes in the average cost of an efficiently produced scan and the degree to which MRI substitutes for other hospital procedures.

In its 1986 April report, the Commission recommended that for three years Medicare should pay hospitals an additional amount (called an add-on) for each covered magnetic resonance imaging scan performed on an inpatient Medicare beneficiary in a PPS hospital. This recommendation was not implemented. Under existing capital payment policy, the add-on for fiscal year 1987 would have been $124 for each scan performed on beneficiaries in institutions where Medicare pays for the capital costs of an MRI scanner. It would have been $282 for each scan performed on beneficiaries in other PPS hospitals. Fiscal year 1988 and 1989 add-on amounts for all hospitals were to be recalculated to reflect any change in the average cost of an efficiently produced scan and any changes in capital payment policy.

The Commission continues to believe that an alternative payment mechanism is necessary to reflect the operating costs for MRI scans. ProPAC is especially concerned about the lack of Medicare payment for capital costs of MRI scans to hospitals that do not own MRI scanners. These hospitals do not qualify for capital pass-through costs of an MRI scan even though they contract to furnish MRI scans to their Medicare inpatients. (See Recommendation 10 concerning institutional neutrality for capital payments.)

While MRI has become a Medicare-covered service for many clinical indications in Medicare beneficiaries, hospital payments have not been increased to reflect the additional costs of using this technology. The Secretary has stated that recalibration will adjust for the cost of MRI. Since recalibration relies on past experience, it is appropriate for stable technologies and services. Recalibration is inadequate for some new technologies during their initial diffusion.

MRI scans are performed on patients in many DRGs. Thus it is unlikely that a single DRG would have sufficient cases utilizing MRI scans to raise payment levels high enough to reflect the added cost of this procedure. Because only a small percentage of PPS hospitals now have MRI scanners, reliance on recalibration to pay hospitals would not direct payments to sites where costs are generated. Over time the increased costs of MRI will be reflected in average DRG weights. In the immediate future, however, the averaging effects of DRG recalibration will tend to underpay hospitals utilizing MRI and to overpay those that do not use the technology. This inequity may discourage hospitals from providing necessary MRI scans.

The failure to pay adequately for inpatient MRI services may further promote inappropriate distribution of MRI scanners in outpatient facilities where Medicare cost-based and charge-based reimbursement results in significantly higher payments. Distorted incentives may encourage performing MRI scans as an outpatient service when inpatient scanning might be more appropriate and efficient. Unbundling of MRI services may result, with increased total payments for the Medicare system. In addition, Part B Medicare beneficiary cost sharing for outpatient services will make the beneficiary responsible for a 20 percent copayment in addition to any beneficiary liability associated with a related hospital stay.

The Commission stresses that an add-on amount should be based on the costs of an efficiently run scanner. The add-on should also be calculated to factor in the savings of substituting MRI for other technologies as discussed in the Commission's Technical Appendixes to the April 1986 report. If the hospital does not use the MRI scanner efficiently, it should be responsible for the resultant losses.

The Commission strongly believes that this add-on payment should not increase total Medicare payments beyond the amount calculated for the scientific and technological advancement component of the discretionary adjustment factor. Targeted payment adjustments of this type should be offset in the DAF so that the total amount allowed remains unchanged by the add-on payment. After three years, the Commission will reevaluate the adequacy of PPS payments for MRI and the need for continuing an add-on.

The Secretary's response to ProPAC's April 1986 recommendation to temporarily pay hospitals an add-on for covered MRI scans indicated

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the desire to avoid establishing a precedent that is contrary to the principle of establishing a single payment for all cases classified within a DRG. In making its recommendation, the Commission recognized that an add-on payment departed from the concept of a single payment for all cases classified within a DRG, regardless of resources used. ProPAC believes that flexibility to accommodate new technologies is important enough to depart from this approach temporarily. The MRI situation is unique in the Commission's opinion. This new, important technology involves patients who will be assigned to many DRGs; an adjustment of individual DRGs would not achieve the goal of appropriately recognizing MRI.

The Commission is aware that this recommendation may create incentives to overutilize MRI scanning for inappropriate clinical purposes. For this reason, the Commission recommends a price consistent with the costs of an efficiently used scanner. The Secretary should take appropriate measures to discourage unnecessary utilization of MRI scanning. This might be accomplished by PRO review of a random sample of cases or by another method chosen by the Secretary. For more information on this recommendation, see Technical Appendix B.

Research on Case-Mix Change

Recommendation 28: Record Reabstraction Study

The Secretary should initiate, as soon as possible, a study of case-mix change based on a reabstraction of medical records of PPS patients. The study should evaluate DRG assignment to distinguish case-mix increases caused by changes in coding practices from changes in treatment patterns and patient mix. The study should serve as the basis on which to develop and refine alternative ongoing data collection methods to monitor case-mix change over time. The Commission will contribute resources to designing, financing, and monitoring this study.

The availability and use of accurate, timely data continue to be critical priorities of the Commission as a basis for policy decision making. Data on case-mix change, a major element in the update factor and an important indicator of hospital response to PPS, have proven to be particularly difficult to obtain and evaluate. HCFA and ProPAC have engaged in various efforts to examine case-mix change, but there is still a need to develop new analytic tools.

HCFA and ProPAC presented and discussed various methods to measure case-mix change at a jointly sponsored symposium on the topic in December 1986. It was generally recognized by symposium participants that case-mix change is a complex issue, which continues to be relevant to efforts to understand and update PPS. The symposium was useful in identifying both the advantages and the limitations of a record reabstraction study. Subsequent conversations between ProPAC and HCFA staff have established that such a study would be most useful in developing, refining, and validating ongoing methods of monitoring case-mix change over time.

A medical record reabstraction study would involve systematically examining medical records and directly measuring real case-mix change over time under experimental circumstances. In this manner, observed changes in relative frequencies of DRGs could be separated into those caused by patient mix and treatment patterns, and those caused by coding practices. This type of study would not provide an estimate of the amount of case-mix change that should be allowed for in future update factors. It would, however, provide the analytic foundation for separating real case-mix change from upcoding.

Preliminary evidence suggests that both real case-mix change and upcoding are becoming less pronounced than in the early years of PPS. Nevertheless, ProPAC's analysis of medical record coding practices indicates there is still substantial potential for additional change (see Technical Appendix A). Further, the implementation of ProPAC's Recommendation 21, which would eliminate age as a patient classification variable, might be accompanied by a renewed incentive to change coding practices. In particular, hospitals would have an increased incentive

to code complications and comorbidities for patients over age 69. The Commission believes this and other potential coding practice changes that might affect case-mix measurement should continue to be monitored.

ProPAC is anxious to begin working with HCFA on identifying and evaluating design options for this study. Several issues need to be addressed in designing the study, including necessary precision, hospital sampling strategies, timing, and methods of reabstraction. In addition, the study design should incorporate a method to examine changes in the amount and type of information recorded on the medical record.

Chapter 3

Analytic Plans of the Commission

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This chapter describes the Commission's analytic agenda for identifying potential improvements to the prospective payment system. These plans reflect ProPAC's continuing efforts to develop an empirical basis for modifying DRG classifications and calculating the payment amounts. The plans flow from the analyses completed to date, either expanding current work or studying new topics.

Since the implementation of PPS more than three years ago, many government and private organizations have become involved in PPS-related research. Considering this growing body of knowledge, the Commission carefully monitors research being planned or in progress. The Commission consults regularly with HHS, HCFA, CBO, and other government entities as well as with professional societies, beneficiary organizations, and other private-sector groups. This enables ProPAC to define an analytic agenda that makes the best use of its limited resources.

Although the implementation of PPS has been largely successful, technical updates and improvements will be necessary to ensure continued equitable payments to hospitals. These include ProPAC's updates of the payment amounts, adjustments to the DRG classifications to reflect changes in medical technologies and practice patterns, and other technical adjustments to the payment mechanism.

The Commission recognizes the need to look beyond the payment mechanism and to study the effects of PPS on hospitals and beneficiaries. Now that the system has been in effect for several years, it is important to examine how hospitals have responded to the incentives of PPS and the effects on beneficiaries' access to high-quality care.

Thus, the Commission's analytic agenda reflects a balance between technical updates and improvements to the payment mechanism as well as efforts to measure and adjust for the effects of PPS. This chapter, which summarizes these analytic plans, is divided into three sections: (1) DRG classification and case-mix measurement, (2) improving and updating the payment amounts, and (3) quality of care and effects of PPS on beneficiaries.

DRG CLASSIFICATION AND CASE-MIX MEASUREMENT

In the past two years, the Commission has considered three broad approaches to improving the measurement of case mix:

- Retaining the current system but revising it incrementally as problems emerge;
- Retaining the system in principle but reconstructing it using newer, more complete data bases; and
- Implementing an alternative system, either in conjunction with DRGs or to replace DRGs.

In its April 1986 report, the Commission recommended retaining the current DRG system along with several incremental modifications and improvements. At the same time, ProPAC voiced its concerns regarding the significant variations in resource use evident within DRGs. The report described the Commission's analytic plan for systematically evaluating these variations.

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The Commission has now completed this evaluation as well as several other studies designed to improve case-mix measurement. These included an analysis of the use of patient age in defining DRGs and two pilot projects on restructuring the list of complications and comorbidities and surgical hierarchies. Based on this work, the Commission has reaffirmed its position on maintaining the DRG system for the present (Recommendation 20) and made several recommendations for improvements (Recommendations 21 through 23).

In the long-term, it may be necessary to develop improvements in the measurement of case mix based on patient information not currently available from the discharge abstract. The Commission believes, however, that it is premature to recommend major DRG reconstruction or implementation of one of the alternative systems that use additional patient data. Some of the alternative systems are still under development, and much of the work needed to evaluate these systems has yet to be initiated. Further, the Commission believes that the administrative costs as well as the benefits associated with the reporting of new data should be considered before adopting any alternative system.

The rest of this section describes ProPAC's analytic plans for improving case-mix measurement. Based on the approaches cited earlier, the Commission's efforts will focus on:

- Developing incremental improvements related to new technologies, specific DRGs, or groups of DRGs;
- Developing more generic improvements in case-mix measurement, such as improved complication and comorbidity lists and adjustments for the unique problems of specialty hospitals;
- Monitoring the development and evaluation of alternative case-mix systems; and
- Developing improvements in other areas related to case mix, such as outlier payment policy and allocation of nursing costs.

Technologies and Practice Patterns

For the past two years, the Commission has analyzed a number of specific problems associated with individual technologies and changes in medical practice patterns. These issues arise from staff analyses and from correspondence with a wide variety of concerned individuals and organizations. Some of the issues emerge when new technologies become Medicare-covered services. For example, in the past year, the Commission studied heart transplantation and cochlear implantation because they became covered services. Other issues surface as practice patterns change. In the coming year, for instance, the Commission plans to study the practice changes related to cardiac catheterization during myocardial infarction.

ProPAC will continue to devote part of its resources to careful review of these issues and further in-depth analysis for selected cases. The Commission will recommend improvements on a case-by-case basis, where appropriate, to incorporate new technologies into the system or to reflect medical practice pattern changes.

The Commission recognizes the difficulties inherent in incorporating new technologies and medical practices into PPS. ProPAC continues to consider improvements that provide appropriate incentives for the development, adoption, and diffusion of new technologies. However, the Commission is careful to avoid promoting the adoption of technologies that are unproven or unnecessary for the efficient delivery of high-quality care.

The current financial incentive to implant the least costly pacemaker device, for example, could have an adverse impact on quality of care. Similar incentives may exist for the implantation of penile prostheses. The Commission is concerned that hospitals, faced with this payment incentive, may deny patients access to new technologies. ProPAC plans to complete a small-scale project to study beneficiary access to expensive devices under PPS. The Commission is also considering committing resources to track the development and diffusion of selected medical technologies so that it can assess how

beneficiary access to new technologies has changed under PPS.

The Commission will also devote resources to studying specific DRGs, or groups of DRGs, which exhibit special problems that may be addressed by modifying the DRGs. In some cases, such as reconfiguring the lymphoma and leukemia DRGs, DRG-specific improvements may be recommended. In other cases, the findings might suggest the need for a more generic policy adjustment, such as addressing the unique problems of specialty hospitals.

Additional coding and assignment issues will be studied for individual DRGs or groups of DRGs. For example, the Commission plans to study DRG 468 (operating procedures unrelated to principal diagnosis). It will recommend refinements to reduce the clinical and resource-use heterogeneity in this DRG. Other issues may include the determination of principal diagnosis and DRG assignment when multiple procedures are performed during a hospital stay.

During 1986, the Commission adopted several principles for improving case-mix measurement. Two of these principles apply not only to new technologies and practice pattern changes but also to more generic improvements like the elimination of age as a criterion for classification. These principles are:

- The analyses supporting the development of recommendations will focus primarily on the Medicare patient population. The Commission will consider other population groups in the development of case-mix measurement recommendations depending on the availability of data and the feasibility of such an effort.

- Where possible, recommendations regarding changes in the DRG classification system will be based on patient diagnostic characteristics that reflect appropriate treatment. At times, however, it will be necessary to recommend DRG classification based on treatment or diagnostic procedures provided.

Further, the Commission believes that, in some situations, it may be necessary to assign new technologies to unique, temporary device- or procedure-specific DRGs. These temporary DRGs will be periodically monitored; the DRG assignment will be evaluated after three years or sooner, if appropriate. The Commission has adopted the principle of calculating a DRG weight using the best data available. Occasionally, however, technologies are in such early stages of diffusion that no adequate charge or cost data will be available. In this case, the Commission will use expert judgment to supplement the best available data.

Case-Mix Measurement Issues

The Commission's case-mix measurement work completed since the April 1986 report has focused on developing refinements in the DRG assignment criteria. These analyses included a systematic evaluation of DRGs to identify potential problems in DRG construction and classification. In addition, the Commission studied the appropriateness of using age as an assignment criterion, and possible refinements to the list of CCs and to the surgical hierarchies. These analyses are reported in Technical Appendix B.

The Commission will continue to study refinements to the DRG system. To some extent this will be limited to monitoring ongoing studies by HCFA and other organizations. It is likely, however, that follow-up analysis or further collaborative work with HCFA will be necessary. The Commission's analytic plans for studying refinements during 1987 are described briefly below.

Patient Age—Patient age is currently used to define 95 pairs of DRGs that distinguish patients who are under 70 from those 70 years or older. Patients 70 years or older are currently grouped with patients who have a CC. Based on work completed since the April 1986 report, the Commission believes that defining DRGs on the basis of having a CC, regardless of age, is more appropriate. As a result, this report encourages the Secretary to eliminate age as an assignment criterion (Recommendation 21).

The Commission also urges the Secretary to study DRGs that currently do not split on the

basis of age and/or CC to determine if splitting these DRGs on the basis of CC alone is appropriate in some cases. During 1987, the Commission will monitor work conducted by HCFA on this issue. If necessary, ProPAC will devote its own resources to complete this analysis.

Complications and Comorbidities—The Commission previously expressed its concern regarding the adequacy of the current list of CCs. Based on work completed since the April 1986 report, ProPAC believes that refining the definition of CCs will improve the ability of the DRGs to capture differences in case complexity. The Commission is aware that HCFA has several studies under way to develop and evaluate modifications to the CC list. The Commission will monitor the progress of these efforts and will evaluate any changes proposed by the Secretary.

It is likely that improvements in the list of CCs (e.g., the use of MDC- or DRG-specific lists) would affect the results of past and future analyses of patient age. Improving the CC lists in conjunction with the elimination of age as a criterion would probably improve the DRGs further. This needs additional study, however.

Operating Room Procedures—The Commission has continued to urge the Secretary to review and update the list of operating room procedures and surgical hierarchies. During 1986, ProPAC completed a pilot study that examined the current surgical hierarchies for three MDCs. The findings indicate that the surgical hierarchies need to be examined on a systemwide basis. A regular evaluation, combining clinical and statistical methodologies, would provide more appropriate surgical procedure groupings and hierarchies. The Commission will monitor closely the efforts by HCFA in this area and evaluate future refinements.

Specialty Hospitals—The Commission has increasingly become concerned that the current DRG classifications and weights do not appropriately reflect the resource use of specialty hospitals under PPS. As referral institutions, these centers may treat only the most complicated cases in a given DRG. Findings from an analysis of burn cases, reported in the April 1986 report, illustrate this point.

Analyses completed since the April 1986 report suggest an even greater need to evaluate specialty centers. The results showed that refinements in the DRGs that significantly increase DRG homogeneity may not have major hospital-level effects. That is, even if the heterogeneity within DRGs can be reduced, the above-average resource costs for patients in certain hospitals remain largely unaffected. To the extent that higher costs are not due to unnecessary treatment or inefficiencies, these hospitals will be paid unfairly under PPS. Specialty hospitals comprise one group of hospitals where this may be true. The Commission plans to continue its analysis of specialty hospitals during 1987 and will recommend improvements where appropriate.

Coding Issues—The Commission has continued to identify problems related to the ICD-9-CM coding system for procedures and diagnoses. ProPAC believes that maintaining and updating the current ICD-9-CM system is critical to ensuring appropriate DRG assignment. ProPAC has identified other areas for further evaluation and plans to continue studying these issues as well as monitoring changes in the coding system. These analyses are likely to include: (1) an evaluation of the extent to which revisions to the DRGs should explicitly consider the use of multiple codes to describe a single disease entity, and (2) whether more explicit, consistent rules for coding patients with multiple conditions or procedures should be developed.

Alternative Case-Mix Measurement Systems

The Commission recognizes that in the long-term it may be necessary to consider an alternative patient classification system to replace or modify the DRGs. However, research comparing the alternative case-mix measurement systems is still at a preliminary stage. It is unlikely that any of the systems could be considered for PPS use in the next one to two years. A comprehensive study on a single data base comparing all the systems has yet to be initiated.

Several of the systems use the same patient discharge data as the DRG system, while others use data not currently available from patient discharge abstracts. Systems using data that supplement what is currently collected may show promise for case-mix measurement. But these systems are largely untested and generally involve additional cost. It is unclear if any of the systems using existing discharge data significantly improves case-mix measurement. The Commission will continue to monitor the development and evaluation of these systems.

Other Issues Related to Case-Mix Measurement

The Commission will continue to devote resources to study issues related to case-mix measurement, including:

- Policies designed to deal with deficiencies in the measurement of case mix, such as outlier payments;
- Technical adjustments or methodological concerns regarding the use of DRGs for payment, such as the allocation of nursing costs; and
- Variations in resource use not accounted for by DRGs.

The Commission plans to study these issues and others related to case mix as they emerge. Specific plans are described below.

Outlier Payment Policy—The Commission is concerned that current outlier payment policy may not result in payments that are related equitably to hospital use of resources. The Commission believes that further research is needed to determine the appropriateness of current outlier policy. Outlier analyses completed by ProPAC indicate that outlier payments and discharges are unevenly distributed across hospital groups and by DRGs. The Commission recommends that risk should be evaluated at both the case level and the hospital level as refinements to the outlier payment policy are developed (Recommendation 17).

The Commission believes that daily costs should be examined to determine the level of financial risk for outlier cases. It plans to fund a major research project to examine costs for particular services for each day of a stay and to identify the major factors that influence variation in the daily incremental cost of care. The results of these analyses should help ProPAC recommend changes in outlier payment policy to reflect more accurately the resources hospitals use to treat outlier cases.

Transfers and Readmissions—Patients who have been transferred between hospitals may be more severely ill than those who have not. This is a more likely problem for selected DRGs, such as burns. The Commission will continue to evaluate transfer policies in the context of individual DRG analyses. ProPAC will study the adequacy of payments for the transferring and receiving hospitals as well as the incentives of current policy.

Changes in readmission and transfer rates may provide empirical evidence about how PPS affects beneficiary access to hospital care. The Commission will examine changes in readmission rates as part of its study of targeted groups of beneficiaries described later in this chapter. Readmissions and transfers also will be studied to monitor hospital responses to PPS incentives.

Nursing Intensity—Nursing intensity variations exist both within and across DRGs. Variations within DRGs are likely to be closely linked to variations in patient complexity, or heterogeneity, which has been the focus of much of the Commission's case-mix measurement work to date. Nursing intensity variations across DRGs currently are not reflected fully in the DRG weights. This was caused by the methods used to allocate nursing costs in calculating the weights.

In its 1985 and 1986 April reports, the Commission voiced its concern about the possible inaccuracies introduced in the DRG weights as a result of nursing cost allocation methods. During 1986, the Commission completed some small-scale research projects and monitored other research to document the magnitude of the problem. Further, using the most recent research findings, ProPAC simulated the effect of

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adjusting the DRG weights to account for nursing intensity.

The simulation results show that adjusting for variations in nursing intensity is likely to have limited effects on DRG weights and hospital case-mix indexes. Thus, no major research is planned at this time. The Commission will, however, continue small-scale efforts to monitor other work and will consider studying specific issues and DRGs.

The Commission recognizes the importance of nursing services in the provision of high-quality hospital care. To date, however, there is little evidence about the relationships among nursing skill mix, the amount of nursing care, and quality of care. During 1987, the Commission will consider committing resources to gain more understanding about this relationship. In developing improvements in the DRGs, ProPAC will continue to consider the ability of the DRG system to promote appropriate levels of nursing services.

Labor/Nonlabor Portions of the Payment Amounts—The Commission has continued to be concerned about DRGs involving expensive implantable devices. The current methodology for the payment mechanism and for DRG weight calculation assumes that approximately 75 percent of costs are labor-related. Payment inequities may occur for DRGs where nonlabor accounts for significantly more or less than 25 percent of costs.

The financial impact of adjusting the standardized amounts to account for the variation in labor portions across DRGs is uncertain. The Commission believes, therefore, that this issue deserves further study. ProPAC will review the findings from research sponsored by HCFA, which was made available recently. Where appropriate, the Commission will initiate further studies to examine the effects of the area wage index and the labor and nonlabor cost portions of the standardized amounts on PPS payments to hospitals.

Medicare Eligibility on the Basis of Disability or End Stage Renal Disease—In 1972, Medicare eligibility was extended to persons with end stage renal disease (ESRD) and persons who had been receiving social security disability benefits for 24 months. The Commission is interested in studying whether beneficiaries who are eligible for Medicare due to ESRD or disability differ from those who are over 65 in terms of the conditions treated and the resources consumed. Significant inequities in payments could reduce access to high-quality care for ESRD and disabled patients.

ProPAC resources already have been committed to other analyses that involve Medicare beneficiaries eligible because of ESRD disability. One of ProPAC's current studies involves analyzing the appropriateness of the coding for ESRD beneficiaries. The Commission's study of targeted groups of beneficiaries is examining characteristics of the disabled population and comparing them with other potentially vulnerable groups (e.g., frail Medicare patients). The Commission is considering committing additional resources to study this issue further.

Variations in Resource Use—Variations in resource use have been the primary focus of efforts to improve case-mix measurement. The objective has been to reduce patient-level variations in charges within DRGs. However, results of the Commission's systematic evaluation suggest that DRG refinements that reduce variations within DRGs on the patient level do not necessarily have important effects on the hospital level. Nevertheless, the refinements may still be desirable to provide more accurate DRG weights.

If hospital-level variations remain largely unaffected by refinements on the fringes of the DRG system, it becomes more important to examine the distribution of hospital-level resource use. The systematic evaluation results demonstrated, not surprisingly, that hospitals with higher charges are more likely to be teaching, urban, and disproportionate share hospitals. The Commission will expand its examination of hospital-level variations as improvements to case-mix measurement are developed.

IMPROVING AND UPDATING THE PAYMENT AMOUNTS

The Commission's objective in improving DRG classification and case-mix measurement is to ensure that payments are distributed appropriately based on the resources required to treat individual patients. In addition to equitable payment distribution, ProPAC believes that determining appropriate aggregate payment levels is critical to the provision of quality care for Medicare beneficiaries. The Commission, therefore, devotes significant resources to this effort.

This section describes the Commission's analytic plans for determining appropriate payment levels and distributing payments to hospitals. It begins with a discussion of ProPAC's analytic plans to support its deliberations on an appropriate change in the base payment amount for hospitals. This is followed by a description of the Commission's research agenda for studying other issues related to the payment amounts. Included here are plans for studying the effect of payment distribution for selected hospital classes and the inclusion of capital in PPS.

Updating the Standardized Amounts

ProPAC is required to develop recommendations regarding the rate at which the Medicare standardized amounts should be updated annually. The update factor consists of two major components—the market basket adjustment and the discretionary adjustment factor. In the recommendation for the fiscal year 1988 rates, the update factor includes a third major component—an adjustment to the standardized amounts based on more recent cost data (Recommendation 2).

The market basket adjustment allows for changes in the cost of the goods and services used by hospitals. Since issuing its April 1986 report, ProPAC conducted several analyses of hospital market basket components. The Commission will continue to monitor market basket issues, but no further analytic efforts currently are planned in this area. The Commission's efforts to continue to refine methods for measuring the components of the DAF and for analyzing the standardized amounts are discussed below.

The Discretionary Adjustment Factor—The DAF is a component of ProPAC's update factor recommendation which reflects judgments regarding four factors that influence the average cost of a discharge. These factors are measures of: scientific and technological advances, hospital productivity, site-of-care substitution, and real case-mix change. In establishing the DAF, the Commission strives to ensure that Medicare inpatient payment levels are appropriate to enable hospitals to provide high-quality, cost-effective care for beneficiaries.

The Commission continues to devote significant resources to refining its measurement of change in the factors comprising the DAF. These efforts include identifying new data sources as well as precise measures of changes in the factors and their interrelationships. Specific analytic activities are described below.

Scientific and Technological Advances—The purpose of this portion of the discretionary adjustment factor is to provide adequate funds for adoption of cost-effective, quality-enhancing technologies. The scientific and technological advances adjustment recognizes the need for an allowance for relatively new technologies that are in the early stages of diffusion.

During 1987, the Commission will attempt to improve its understanding of technology diffusion and its impact on Medicare costs per case. Particular emphasis will be placed on determining the point at which a technology has diffused adequately so that additional funding through the DAF is no longer necessary.

Productivity—The Commission will refine its efforts to measure total factor productivity, accounting for changes in outputs that are produced by a given level of inputs. Total factor productivity refers to productivity measures that reflect labor, nonlabor, and capital inputs. The Commission's work will attempt to more directly reflect the fact that outputs tend to change more rapidly in the hospital industry than in other industries.

In 1987, the Commission will continue to examine measures of total factor productivity based on per day and per admission measures of

output. Analysis will focus on empirical measures of hospital productivity that are developed by aggregating productivity measures for individual hospital departments. Data will be refined to permit measurement of productivity based on departmental units of service. The Commission also plans to refine the unadjusted measures to account for changes in skill mix, occupancy rates, and the DRG case-mix index.

Site-of-Care Substitution—In order to measure site-of-care substitution, data must be obtained about services provided to a patient both in and outside of the hospital for an entire episode of illness. CBO and ProPAC have recently created a data set that links Medicare Part A and Part B billing data, by beneficiary, for an episode of illness. ProPAC plans to use these data to quantify the amount of site-of-care substitution that has occurred.

Concurrently, the Commission plans to develop proxies for site-of-care usage to measure total resources consumed during an episode of illness. ProPAC also will examine shifts in the site of care for selected procedures and changes in the proportion of procedures or services delivered on an outpatient basis.

Real Case-Mix Change—The Commission recognizes three sources of case-mix change: changes in case complexity within DRGs, changes in patients and treatments across DRGs, and changes in coding practices that result in different DRG assignments.

Only the first two sources are considered real case-mix change because they reflect changes in patient resource requirements. Therefore, they are the only types of change relevant to the DAF. Changes in patients and treatments across DRGs and changes in coding practices are reflected in the case-mix index. Thus, it is important to separate real case-mix change from coding change.

The Commission is undertaking two major efforts to measure real case-mix change. The first is the continuation of a study conducted to provide estimates of real case-mix change across DRGs. The methodology minimizes the effects of coding changes on the case-mix index by using an "optimized" DRG case-mix index for 1984 through 1986. Specifically, this technique estimates what the DRG case-mix index would have been for the period if hospitals had coded all cases in a manner that maximized reimbursement within plausible constraints. The Commission plans to validate and refine this methodology to improve measures of real case-mix change over time.

In its second major effort, ProPAC plans to participate in a medical record reabstraction study designed to distinguish between real case-mix change and changes due to coding practices. ProPAC will work with HCFA to design and fund this study. Medical records will be systematically examined to directly measure case-mix change over time. The most important use of data from this study will be the validation of alternative indirect methods for estimating case-mix change, which can be applied to ongoing analyses.

Finally, the Commission will continue to examine medical record coding changes and how these changes may affect case-mix index change. The Commission also will refine and update measures of case-complexity change within DRGs.

Studies of Cost Report Data—The Commission examined first-year PPS cost data to determine both changes in costs per case since 1981 and hospital financial status. These analyses provided valuable information for the Commission's deliberations regarding an appropriate update for the payment amounts. As more recent data become available, the Commission will continue to examine these issues.

The timely availability of Medicare Cost Report data is essential for analyzing the effects of PPS on hospitals. A study conducted by the Rand Corporation for ProPAC demonstrated that cost data received early in the fiscal year can be used to estimate the cost characteristics of PPS hospitals as a whole. ProPAC will sponsor another analysis to determine if a similar early return sample can be developed for PPS-excluded hospitals.

ProPAC also plans to investigate issues related to the validity of Medicare Cost Report data submitted during PPS years. Specifically, the Commission plans to examine the cost-finding process used in the cost report as well as the accuracy of the data reported by hospitals.

Finally, the Commission plans to combine Medicare Cost Report data with patient billing data. Analyses will be conducted regarding the appropriate data for recalibrating the DRG weights, estimating capital cost variations across DRGs, and comparing costs and payments for individual DRGs.

Other Issues Related to the Payment Amounts

Besides conducting analyses to support recommendations for the update factor, the Commission will continue to examine selected policies that also affect the level and distribution of payments to hospitals. The Commission will focus on those policies that may systematically underpay or overpay hospitals. It also will examine whether PPS is an appropriate payment mechanism for selected hospitals because of their unique cost structures. Finally, the Commission will continue to examine issues arising when capital is incorporated into PPS payments.

In order to address these issues, the Commission plans to conduct analyses that will provide information on the nature of variations in costs among hospitals. Such information will provide insight into the potential impact of future PPS policy decisions on hospitals. Additional details regarding ProPAC's analysis of other payment issues are provided below.

Excluded Hospitals—Although psychiatric, rehabilitation, pediatric, and long-term care facilities are excluded from PPS, ProPAC is required to recommend an update factor for the target rate of increase limits for these hospitals. In 1987, the Commission will continue to examine the differences in the cost structure of excluded hospitals compared with PPS hospitals.

Research will emphasize understanding how PPS incentives affect the performance of excluded hospitals. This information will be used to develop an appropriate update factor for these hospitals. The Commission will study the impact of changes in case mix and site of care on these hospitals' costs and service delivery. ProPAC also plans to extend its productivity study, described in the section on the DAF, to excluded hospitals.

Rural Hospitals—The Commission believes that some PPS policies may systematically place rural hospitals at a disadvantage. To determine the extent of problems rural hospitals face, the Commission plans to undertake two efforts. The first will define and examine the financial risk that small, isolated rural hospitals must overcome and the factors in PPS that may exacerbate this risk. Second, the Commission will identify changes in urban and rural hospital cost structures for the period 1981 through 1985, and the implications of these changes for PPS payment policy.

ProPAC will also examine differences between urban and rural hospitals in its study of other issues discussed in this chapter. For example, rural hospitals will be a unit of analysis in the Commission's studies of case-mix change and outlier payments.

Capital Payment Under PPS—Since its 1986 report, the Commission has conducted several analyses related to the capital payment issue. As a result of these analyses, ProPAC has reaffirmed and revised some of its 1986 capital payment recommendations. Because future Medicare capital payment policy remains unclear, the Commission plans to continue its analysis of this issue in 1987.

Several capital payment implementation issues remain on the Commission's analytic agenda from 1986. These issues include study of geographic variations in construction costs, inclusion of capital in the hospital market basket, and the effect of capital on other PPS payment components. Although ProPAC has studied these issues, the Commissioners found it difficult to incorporate these analyses in recommendations because of the uncertainty of future policy. ProPAC continues to believe the issues are important for the implementation of new capital payment policy and plans to continue

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examining these areas. Other specific analytic activities are outlined below.

Analysis of Vulnerable Hospitals Under New Capital Payment Policy—The Commission will continue to examine hospitals that may be financially vulnerable under new capital payment policy as a result of current or near-term capital obligations. Using an investment model, ProPAC will monitor the potential effects of a new capital payment system on hospitals (see Technical Appendix A). The Commission plans to examine closely the number and characteristics of hospitals that may be financially vulnerable under new capital payment initiatives. Efforts will focus on identifying financing mechanisms that may assist hospitals during a transition to a new capital payment system and how hospitals can take advantage of such mechanisms.

DRG Capital Intensity Variations—The Commission believes that the payment system adopted should reflect the capital resources consumed during an inpatient stay. It will study whether the existing charge-based weights accurately reflect the capital intensity of each DRG. The Commission plans to examine the variation in capital resource intensity across DRGs as well as within selected DRGs. Analysis results will help determine whether it is appropriate to distribute capital payments on the basis of existing DRG weights, or if some alternative payment method is necessary.

Hospital-Level Effects of PPS

The Commission continues to be concerned about the effects of PPS on hospitals, particularly the adequacy of payment levels and the distribution of payments across types of hospitals. Analyses of hospital costs and payments contribute to the Commission's annual update factor recommendations and to ProPAC's annual report on the impact of PPS. In the long-term, these analyses will also provide insight into the effect of PPS incentives on hospitals.

The Commission will continue to model PPS payments focusing on the distribution of payments across hospitals. ProPAC's analysis will update information on the distribution of payments, including adjustments for teaching, disproportionate share, and outliers across hospital types. The Commission will study further differences in case-mix index change across hospitals. Results will provide information about the extent to which hospitals must adapt to the new incentives and requirements of PPS. Such payment reallocations ultimately may affect whether the hospital industry can continue to provide Medicare beneficiaries with quality care.

Management Strategies and the Administrative Cost of Care

The Commission intends to continue its examination of selected hospital managerial strategies and their potential effect on the cost and quality of care. Using existing data sources, ProPAC plans to study the effects of strategies adopted by hospitals to improve efficiency. The Commission will study possible differences in labor expenses and skill mix between hospitals that implement selected strategies and those that adopt alternative strategies. The Commission also plans to examine changes in services provided by hospitals. Specifically, ProPAC is interested in evaluating strategies that are designed to change or reduce selected services.

In addition, ProPAC will examine the administrative costs of providing inpatient hospital care. Analysis will identify the costs of managing the Medicare program. It will also study the administrative costs hospitals incur in delivering care to beneficiaries. The Commission especially is interested in the extent to which hospital administrative costs are changing relative to changes in patient care costs. To study this issue, the Commission plans to examine changes in the ratio of administrative personnel to patient care personnel per admission since the beginning of PPS. While the study of administrative costs will not generate exact estimates, it will provide information regarding the general magnitude of such costs.

QUALITY OF CARE AND EFFECTS OF PPS ON BENEFICIARIES

Since the beginning of its work, one of the Commission's highest priorities has been to ensure that Medicare beneficiaries have access

to high-quality health care. The prospective payment system was designed with financial incentives to encourage hospitals to provide care in the most cost-effective manner. Some methods to achieve lower costs, however, could lead to inappropriate reductions in quality or access to care. The Commission therefore evaluates all technical and analytic work with consideration for its impact on quality of care.

The financial success or failure of hospitals, for example, can affect access to high-quality health care for Medicare beneficiaries. Thus, the Commission's recommendations related to payment amounts under PPS are developed with attention to the impact that over- or underpayment may have on access and quality. ProPAC is aware of the wide variability in the financial status of individual hospitals. An adequate payment amount for one hospital, or class of hospitals, may be quite inadequate for another.

The Commission's continued work on rural hospitals, and past work on disproportionate share hospitals, also demonstrates its concern with quality and access to care. For these hospitals, the Commissioners have been concerned that inadequate payment amounts may result in hospital closures or the inability of hospitals to accept some patients. Either result would compromise access to care. Similarly, quality might be reduced inappropriately if inadequate revenues constrain the expenditure of resources to care for patients.

Changes in the use of and payment for new technologies can also affect the quality of care delivered to beneficiaries. The Commissioners wish to ensure that PPS does not inhibit the development and diffusion of new technologies. On the other hand, ProPAC would find the inappropriate adoption of new technologies unacceptable. It has addressed these concerns by implementing a series of approaches for adjustments to PPS that can help foster the appropriate adoption of new technologies.

These are examples of how ProPAC's major activities—recommending payment amounts and adjustments to the DRGs — relate to quality of care. In addition, the Commission will continue to devote significant resources to activities more directly related to quality and access. These are described below.

General Monitoring Activities

The Commission monitors others' quality of care efforts to avoid duplicating work under way elsewhere. For example, ProPAC recognizes the important and evolving role of the PROs in ensuring quality of care under PPS. During 1987, the Commission will intensify its existing study of PRO responsibilities, particularly those related to quality of care review. ProPAC also will monitor the role and responsibility of the SuperPRO and its impact on quality of care.

Analytic Agenda for Quality of Care Research

In 1985, ProPAC undertook several efforts to provide a foundation for its quality of care and access research strategy. During 1986, the Commission initiated a major analytic project—the transitional care study—as well as other intramural and extramural studies related to quality of care. Research activities planned for 1987 are described below.

Study of Transitional Care—The Commission's major analytic project focuses on post-acute or transitional care services available to Medicare beneficiaries. ProPAC currently is funding a study by Lewin and Associates to review the availability, provision, and cost of care provided in a hospital after the acute portion of the hospital stay has been completed. This effort will include a:

- Synthesis of existing literature and information about post-acute and transitional care,
- Nationwide survey of hospitals in cooperation with the American Hospital Association, and
- Series of case studies.

Study of Targeted Groups of Beneficiaries—The Commission also will analyze Medicare claims data for subgroups of beneficiaries who may be at greater risk of adverse outcomes if

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quality of care deteriorates. ProPAC has identified three vulnerable subgroups for initial study: frail beneficiaries (defined on the basis of age and clinical status); disabled Medicare beneficiaries; and dual Medicare-Medicaid eligibles. These groups have been chosen because the Commission believes that their health status may be a sensitive measure of changes in quality of care.

Review of PRO Denials of Inpatient Care—PPS and the PRO review that has accompanied the system have decreased both hospital admissions and length of stay. Although the impact of shortened lengths of stay has been examined, little attention has been given to those patients who are not admitted to the hospital.

Because it wants to learn more about these patients, ProPAC plans to complete an initial study of this issue in the coming months. This project will review the PROs' role in denial of inpatient care. Even though few patients actually are denied admission by PROs, the techniques, standards, and criteria used by individual PROs to make these denials will provide valuable insights into changes in hospital admission practices.

Review of Hospital Quality Assurance Systems—The Commission is interested in better understanding hospitals' efforts to monitor the quality of care they deliver. Many hospitals have developed or purchased quality assurance systems to help them monitor quality of care. The Commission will review these systems in 1987 to gain a more thorough understanding of how and why they are developed and used.

Additional Areas of Future Concern

The Commission's legislative mandate provides that one method to be used in developing its recommendations involves identifying medically appropriate patterns of health resource use. The law further states that ProPAC shall accomplish this work by collecting and assessing a wide variety of information on medical and surgical procedures and services, including information about regional variations of medical practice. Special attention, according to the law, is to be given to treatment patterns for conditions that appear to involve excessively costly or inappropriate services that do not add to the quality of care.

To date, the Commission has used this authority only in a general way. In 1987, ProPAC will consider how to expand its work in the areas of appropriateness of medical care and practice pattern variation. ProPAC considers these two areas inexorably linked to quality of care.

The variations in medical care across this country have been well documented during the past decade. There are major differences in rates of surgery, length of hospital stay, and hospital admission rates from one geographic location to another, or even within the same institution. Whether the observed differences indicate that beneficiaries receive too much or too little care, depending on where it is administered, requires careful and critical study.

The differences in practice patterns, by definition, raise questions about quality of care. It generally is agreed that invasive techniques and hospitalization always pose a certain level of risk to the patient. While studies have demonstrated significant variation in practice patterns, there is no evidence about their relative efficacy or what constitutes appropriate medical care.

Inappropriate and unnecessary care is not high-quality care. The development of criteria and standards is essential in formulating the basis for medical care decision making. While it is inappropriate for ProPAC to develop such criteria and standards, they would enhance the Commission's ability to assess whether care is appropriate or inappropriate in given situations.

The Commission intends to begin to educate itself in these areas of practice pattern variation and appropriateness of care in the coming year. Such efforts will enable ProPAC to more carefully define how these problems should be viewed in the context of the Medicare prospective payment system.

Financial Effects of PPS on Beneficiaries

The Commission continues to be concerned about the increasing proportion of health care costs paid by beneficiaries and how this burden affects access and quality of care. The inpatient hospital deductible and daily coinsurance rates rose substantially as a result of declines in length of stay, which are largely attributed to PPS incentives. Further, the shift of some services from inpatient hospital treatment to ambulatory settings may have increased beneficiary out-of-pocket costs.

ProPAC has been working with CBO to develop a data base for studying beneficiary cost-sharing changes and increased liability because of site-of-care substitution. The data base merges Medicare Part A and B billing data for a 1 percent sample of beneficiaries for calendar years 1980 and 1985. It combines Part A inpatient hospital, skilled nursing facility, and home health agency records with Part B outpatient hospital, physician services, other medical services, and supplies records.

This data base will be used to estimate and compare the average total liabilities of Medicare beneficiaries for 1980 and 1985. Enrollees will be distinguished by their eligibility status and by use of service. For example, patients with inpatient hospital stays will be differentiated from those without such stays. As described earlier, the level of site-of-care substitution also will be analyzed using this data base.

[FR Doc. 87-13121 Filed 6-5-87; 3:56 pm]
BILLING CODE 4120-01-C

Need for Information on PPS

In one of its first research efforts during 1985, ProPAC studied the perceptions of quality of care under PPS. The Commissioners believed that this was important because perceptions play a large role in expectations, and anecdotes of seriously diminished quality under PPS were being circulated. ProPAC therefore asked Health Economics Research, Inc. to study incidents related to quality of care under PPS.

Incidents reported in the media were reviewed as well as letters from Medicare beneficiaries made available by the American Association of Retired Persons. The study identified a lack of understanding about PPS and how it was supposed to work. The study clearly showed the extent of misinformation circulating among beneficiaries and providers.

ProPAC believes that this breakdown in communications is a major problem, and thus has recommended that the Secretary take remedial steps to ameliorate it. The Commission will continue to monitor the situation by assessing materials available from HCFA and from beneficiary and provider groups. In addition, ProPAC will maintain contact with these groups to solicit their suggestions and concerns about communications problems.

ProPAC also will study the best way to systematically review and document reported incidents of quality of care declines since the beginning of PPS. The study might involve population-based surveys or interviews with leaders of organizations representing beneficiaries and providers.

Federal Register

Wednesday
June 10, 1987

Part V

Environmental Protection Agency

40 CFR Ch. I

Technical Assistance Grants to Groups at National Priorities List Sites; Advance Notice of Rulemaking and Request for Comments

ENVIRONMENTAL PROTECTION AGENCY

Office of Solid Waste and Emergency Response

40 CFR Ch. I

[SARA 117(e); FRL 3166-6]

Technical Assistance Grants to Groups at National Priorities List Sites; Advance Notice of Rulemaking and Request for Comments

AGENCY: Environmental Protection Agency (EPA).

ACTION: Advance Notice of Rulemaking; Request for Comments.

SUMMARY: Pursuant to section 117(e) of the Superfund Amendments and Reauthorization Act of 1986 (SARA) (Pub. L. 99-499), the Environmental Protection Agency ("EPA" or "the Agency") is considering publication of interim rules regarding the technical assistance grant program. This Advance Notice of Rulemaking (ANRM) discusses and solicits comments on several issues and on various approaches that the Agency may consider for accepting, evaluating, and managing technical assistance grant applications. The Agency will consider these comments in formulating an Interim Final Rule.

DATE: Written comments must be submitted in triplicate on or before July 27, 1987.

ADDRESS: Send written comments to: Superfund Docket Clerk, Office of Emergency and Remedial Response (WH-548D), Room LG-100 U.S. Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460. Comments on today's rule should identify the regulatory docket as follows: "Docket SARA 117(e) Technical Assistance Grants Regulation."

The public docket for Superfund materials is located in the Sub-basement, LG-100, U.S. Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460, and is available for viewing from 9:00 a.m. to 4:00 p.m. Monday through Friday, excluding holidays, by appointment only. For appointments, contact the public docket at (202) 382-3046.

FOR FURTHER INFORMATION CONTACT: The RCRA/Superfund Hotline from 9:00 a.m. to 4:30 p.m., Monday-Friday, toll free at (800) 424-9346 or in Washington, DC at (202) 382-3000. For specific information, contact: Daphne D. Gemmill, Office of Emergency and Remedial Response (WH-548A), U.S. Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460, (202) 382-2460.

SUPPLEMENTARY INFORMATION: Today's Advance Notice of Rulemaking has the following sections:

Introduction

Cleanup of Superfund sites requires detailed technical study of site conditions and wastes, analysis of methods and techniques for remediation, and decisions based upon a balanced consideration of statutory and regulatory factors. Despite these complexities, EPA and States need and continue to benefit greatly from thoughtful, informed comment from the public living near these sites. Such informed comment and input are crucial to decision-making for clean-up at Superfund sites. The technical assistance grants authorized under section 117(e) of SARA provide a means to obtain more informed comments from the affected community.

Section 117(e) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, (CERCLA), 42 U.S.C. 9601 et seq., also known as Superfund, as amended by SARA, authorizes the President to make technical assistance grants, up to $50,000, to groups of individuals to obtain assistance in interpreting technical material related to Superfund cleanups at facilities listed on the National Priorities List (NPL). SARA requires the President to promulgate rules for making these grants before processing any grant applications.

EPA has been delegated the authority to issue these rules and has decided to issue an Interim Final Rule (IFR). This IFR will address issues related directly to the technical assistance grants program and enable the Agency to issue grants while continuing to receive additional comments that will be considered in the development of the Final Rule. The Interim and Final Rules will detail the specific requirements for obtaining technical assistance grants. In addition grant applicants for technical assistance grants must meet the requirements of the grant regulations in 40 CFR Part 30 and procurement regulations in 40 CFR Part 33 (see Appendix for summary of requirements). The Agency will review and evaluate all applications based on the criteria set forth in these regulations as well as the technical assistance grant regulation.

This Advance Notice of Rulemaking (ANRM) is being published today to solicit comments the Agency will consider in developing the IFR. The following sections (1) discuss the statutory requirements relating to this program and (2) describe issues on which the Agency specifically wishes to solicit public comment in structuring the rules for these grants. Although the Agency encourages comments on these questions, comments on other aspects of the technical assistance grant program are also welcome.

Statutory Language: Section 117(e) Grants for Technical Assistance

Section 117(e) of CERCLA contains the following authorities regarding grants for technical assistance:

"Subject to such amounts as are provided in appropriations Acts and in accordance with rules promulgated by the President, the President may make grants available to any group of individuals which may be affected by a release or threatened release at any facility which is listed on the National Priorities List under the National Contingency Plan. Such grants may be used to obtain technical assistance in interpreting information with regard to the nature of the hazard, remedial investigation and feasibility study, record of decision, remedial design, selection and construction of remedial action, operation and maintenance, or removal action at such facility.

The amount of any grant under this subsection may not exceed $50,000 for a single grant recipient. The President may waive the $50,000 limitation in any case where such waiver is necessary to carry out the purpose of this subsection. Each grant recipient shall be required, as a condition of the grant, to contribute at least 20 percent of the total of costs of the technical assistance for which such grant is made. The President may waive the 20 percent contribution requirement if the grant recipient demonstrates financial need and such waiver is necessary to facilitate public participation in the selection of remedial action at the facility. Not more than one grant may be made under this subsection with respect to a single facility, but the grant may be renewed to

facilitate public participation at all stages of remedial action."

Grant Application Process

The first step in a grant application process is for the appropriate group to complete a grant application form meeting the criteria set forth in relevant regulations. (An important part of the application will be a detailed scope of work outlining activities to be undertaken by a technical adviser.) In this case, the relevant regulations would be the Interim Final Rule on Technical Assistance Grants and 40 CFR Parts 30 and 33, which cover Agency grant and procurement requirements. The Interim Final Rule will address the key issues dealing with the submission and administration of the technical assistance grant, which are not detailed in SARA. The application is submitted to the lead Agency, which then follows a standard review process to ensure that the application is complete and meets all applicable regulations. Once the grant is awarded, the group receiving the grant must follow 40 CFR 33 in obtaining the services of technical advisers.

If a group is interested in obtaining a technical assistance grant, they first should identify the lead Agency, which may be EPA or the State. EPA could issue the grants directly, or since the States already play a significant role in the Superfund program, EPA could administer this program through the States. In the ANRM, the Agency is seeking comments on the appropriate role for the States in administering the technical assistance grants. Before applying for the technical assistance grant, however, a group must determine the appropriate time to submit the application. In this ANRM, the Agency is seeking comments on whether the grant application can be submitted as soon as a site is placed on the NPL, or cannot be submitted until work is planned or has been initiated. The group must then determine whether they are eligible to apply based on criteria that will be specified in the Interim Final Rule. In the ANRM, the Agency is seeking comments on how to define "groups of individuals which may be affected by a release or threatened release" and the role of local government and other parties. In addition, since only one grant may be issued for each-site on the NPL, groups may need to consolidate their grant applications with other eligible groups or may need to be so constituted as to represent the collective concerns of the entire affected community. In the ANRM, the Agency is seeking comments on ways to ensure that the grant is awarded to the appropriate representative group at each site. Next, the group must decide what activities the technical adviser should perform, how much they will cost, and whether it is appropriate to ask for waivers to the $50,000 ceiling on the grant award or the 20% matching requirement, in order to fill out the application form. In this ANRM the Agency is seeking comments on the activities that are eligible for funding, and on the criteria for determining whether and under what circumstances waivers for the $50,000 limit and 20% matching requirements will be granted. Finally, the application is submitted to the lead Agency for processing.

State Involvement in Administering the Technical Assistance Grant Program

Under CERCLA the States are encouraged to take a more active role in remedial action decisions. The statutory language of SARA states that "in accordance with rules promulgated by the President, the President may make grants available to any group of individuals . . .". It may be possible, then, for EPA to either issue grants directly or make grants available through other parties such as the States. To date, numerous elements of the Superfund program are being implemented by States through cooperative agreements. The Agency therefore must determine the appropriate role of the States in administering the technical assistance grant program.

One of several options under consideration is to allow the States to administer the progam. Under this option, a participating State would receive and evaluate grant applications from its citizens and administer all aspects of the grant agreement. States would also monitor fiscal management of the grant. The States would consult with EPA prior to awarding a grant.

Another variation of this option is for States to administer the program by cooperative agreement for all State-lead NPL sites, that is, sites at which the State is administering similar elements of the Superfund program such as remedial design and construction activities. EPA would then administer the technical assistance program for all Federal lead sites. However, a State could volunteer to administer the program for Federal-lead sites. Again, the State would consult with EPA prior to awarding a grant.

Still another option would be to administer the program entirely at the Federal level during the period that the IFR is effective, i.e., from the promulgation of the IFR to the publication of the Final Rule. After this initial period, the States could administer the program as outlined in the above options.

In the options where EPA would manage the technical assistance program at Federal-lead sites, EPA would consult the States before making decisions regarding eligibility, waivers, and awards. The requirements in the statute for State involvement could lead to a greater role for the States, even if the Federal government is administering the Technical Assistance Grant program. For example, State concurrence could be required before the EPA agrees to issue a grant.

The Agency solicits comments on these and other approaches to State involvement in administering the grant program.

When Grants May Be Available

Section 117(e) of CERCLA authorizes grants for sites on the National Priority List. For many sites on the NPL, the Agency has not yet begun site investigations, at issue is whether grants should be provided for NPL sites for which EPA removal or remedial investigations have not yet begun.

Since the purpose of the grants as stated in section 117(e) is to "interpret information with regard to the nature of the hazard, remedial investigation and feasibility study, record of decision, remedial design, selection and construction of remedial action, operation and maintenance, or removal action at such facility," the commencement of a remedial investigation could be seen as a prerequisite for technical assistance grants. The Agency's intention is to accept applications only for sites where a remedial investigation or feasibility study and/or design and remedial action are underway, or are planned to begin within one year on EPA's annual Superfund Comprehensive Accomplishments Plan (SCAP) (an annual plan of site work scheduled to be undertaken during the coming fiscal year.) However, another option is to accept applications at any time after a site has been listed on the final NPL.

The Agency solicits comment on this issue. Should applications be accepted only for NPL sites where work is underway or planned or any time prior to the remedial investigation, taking into consideration the time it takes to process grant applications and procure technical assistance? Should grant expenditures be keyed to when actual response work (i.e., removal activities or remedial investigations) has started?

Groups Eligible for Grants

EPA is particularly interested in assuring that it has high quality, well informed public comment on its decisions regarding response actions at Superfund sites. This process can be greatly facilitated by providing a means for affected individuals to be informed better of EPA's options and proposed actions. The technical assistance grants authorized in section 117(e) can assist interested community groups in obtaining needed information and interpretative assistance.

Section 117(e) of SARA provides that "the President may make grants available to any group of individuals which may be affected by a release or a threatened release at any facility which is listed on the National Priorities List under the National Contingency Plan * * *."

There are four issues regarding eligibility: (1) Defining "affected groups"; (2) determining whether groups can apply individually or must consolidate their applications; (3) determining if certain groups should be ineligible to receive a grant; and (4) determining whether certain community representation should be required of the grantee organization to ensure that broad community interests are represented.

Defining Affected Groups:

The first issue in defining the scope of eligibility is interpreting the term "group of individuals which may be affected." One approach could be to accept applications *only* from groups of individuals who can demonstrate direct ties to the site (e.g., individuals who are directly threatened by the site from a health or economic standpoint). This approach would reduce the number of groups potentially eligible to participate in the program, and thereby facilitate implementation of the program by reducing the potential for delays caused by conflicts among groups wishing to submit grant applications. Another approach could be to allow the involvement of groups with more distant connections to the site (e.g., the same watershed use), in addition to those groups next to the site. The rationale for this addition would be that the program might benefit by involving citizens whose concerns differ from those of citizens directly affected by the site. This broader involvement may be more appropriate for sites that affect a widespread population area, such as in the case of a municipal well field or water intake threatened with contamination.

Consolidation:

Section 117(e)(2) of CERCLA states that, "[n]ot more than one grant may be made under this subsection with respect to a single facility . . . ." This language suggests that only one group can receive the grant for any particular site. A wide variety of different and potentially eligible groups, however, could be affected by the site; the concerns of a group immediately adjacent to the site, for example, might differ from those of a group that is farther away.

What should the State or EPA role be if any, in consolidating interested groups wishing to receive a grant? One option would be for the State or EPA to accept only one grant application from each site. If more than one were received, then no grant would be awarded until the groups had combined their applications. Another option is a public notice of receipt of an application, e.g., in a local newspaper. The notice would inform others in the community that they have an opportunity to join the original applicant to prepare a single application. Another alternative would be to accept multiple applications and then to fund the one that best meets certain eligibility criteria.

The Agency solicits comments on ways to help ensure an appropriate award of one grant per site. If groups in a community are unable to agree on a single application, what criteria should be used to select among groups competing for the grant? Should EPA make a grant in such situations?

Ineligibility:

Section 117 of CERCLA does not specifically exclude any groups from grant eligibility. EPA questions whether municipalities meet the definition of "group of individuals," and therefore would be eligible to receive a grant under this section. There are other groups which EPA believes may not be appropriate grants applicants. For example, should a party who is potentially responsible for cleanup costs at the site be considered in the award of a grant? Similarly, national or State associations with broad policy interests rather than local concerns, might be ineligible. Other possible exclusions might be academic institutions, profit-making organizations, local government advisory groups or citizens advisory groups. EPA is seeking comment on the appropriateness of excluding these or other groups from eligibility under Section 117.

Existing EPA regulations allow grant funds to be awarded to both incorporated and unincorporated entities. Given that EPA intends the submission of a grant application to be an assurance that the applicant is able and willing to meet EPA grant and procurement regulations, EPA is seeking comment on whether a group's organization status is a good indicator of which groups will be able to manage better the financial and other obligations associated with an EPA assistance agreement. If EPA requires its grantees to be incorporated, does the entire coalition have to incorporate or can one of the coalition member groups, which is incorporated, be the grant recipient?

Representation:

To the extent that groups consolidate in applying for a grant, broad-based representation of interests would be fostered. In some cases consolidation may not come about because only one group may apply for a grant. Even if consolidation occurs, it may still involve only certain interest groups. At issue then, is whether EPA should identify certain community interests that the applying organization should include.

Should coalitions or groups include individuals who are otherwise excluded from receiving grants? For example, should representatives of the municipal or county governments or potentially responsible parties (PRP's) be routinely included or should inclusion be by invitation only of the grant recipient?

EPA specifically seeks comment on possible roles for local governments in this program. For example, should a local government routinely, or at only the recipient's request, participate in management of the grant including monitoring fiscal aspects of the grant? Other potential roles for involving local governments may include helping citizen groups coalesce to prepare a single application, and providing expert advice.

EPA is seeking comments on whether to ensure that groups receiving grants should be representative of a broad range of community interests, and, if so, how this can be achieved.

Activities Eligible for Grants

The Agency must determine the specific activities that are eligible for grants. Section 117(e)(1) of CERCLA states that, "Such grants may be used to obtain technical assistance in interpreting information with regard to the nature of the hazard, remedial investigation and feasibility study, record of decision, remedial design, selection and construction of remedial action, operation and maintenance, or removal action at such facility."

Based on the language in section 117(e), one option is that the Agency could choose to fund only the costs of technical advisors hired to interpret publicly available technical information at National Priorities List sites developed by Federal or State agencies (or their contractors) or potentially responsible parties. The kinds of information that the technical advisor would review under this option would include those documents now routinely reviewed by the public such as:

- Remedial Investigation/Feasibility Study (RI/FS) Work Plan;
- Remedial Investigation/Feasibility Study;
- Health Assessment;
- Record of Decision (ROD); and
- Other public documents included in the Agency's Administrative Record.

As a second option, the Agency could choose to fund activities, in addition to interpreting Agency documents, that would also contribute to the public's understanding of overall site activities and decision-making. Activities or items in addition to interpretation of Agency documents might include:

- Visits to the site area by technical advisors at appropriate times to help advisors understand cleanup activities and then explain them to the public;
- Review and assembly of public documents provided by others;
- Meetings at which technical advisors explain technical information to community residents;
- Assistance to the public in communicating concerns regarding documents reviewed by the technical advisors;
- Overhead expenses for technical advisors, once employed, such as office space and equipment; and
- Travel by technical advisors to conferences and public meetings directly related to the situation at the site.

The Agency solicits comments on these or other options for activities that should be eligible for funding and which ones, if any, should be limited or excluded. The Agency is examining options on governmental cost recovery of expenditures for this program.

Activities Ineligible for Grants

The legislative history of section 117(e) provides that the technical assistance grants are not intended to be used to "underwrite legal actions." EPA believes that it would be inappropriate to allow costs incurred by a community group in preparing for or participating in any adjudicatory proceeding to be paid from a technical assistance grant. Information developed as a result of the grant can, however, be used in litigation. (See last section for issues regarding conflict of interest involved in litigation.)

Waivers of Matching Funds Requirement

Section 117(e)(2) of CERCLA states that, "Each grant recipient shall be required, as a condition of the grant, to contribute at least 20 percent of the total costs of the technical assistance for which such grant is made. The President may waive the 20 percent contribution requirement if the grant recipient demonstrates financial need and such waiver is necessary to facilitate public participation in the selection of remedial action at the facility." For a group to receive a grant, that group must contribute an amount equal to 20 percent of the total project costs. For example, if total project costs were $20,000, then the group would have to provide $4,000 (20 percent of $20,000) to "match" EPA's grant of $16,000. Recipients may not use other federal funds to meet the "match" requirement.

In other governmental financial assistance programs, *in-kind* contributions may be used instead of money to count towards the "match." In-kind contributions are the recipients' non-cash contributions, such as the value of donated goods and services that are properly allocable to and allowable under the given project. To the extent allowed under existing grant regulations, in-kind contributions could reduce the need for groups to raise money in order to receive assistance and therefore reduce the need for waivers. On the other hand, a cash contribution could be viewed as an indication of commitment of a grant applicant.

Since the law allows EPA to consider waivers, we must consider whether, and under what circumstances, such waivers might be used. Waivers are granted totally at the agency's discretion. If the agency allows in-kind contributions to be used, waivers of the 20 percent match might not be appropriate. We would like to solicit comment on whether or not use of such a waiver is felt to be necessary.

If waivers are used, EPA will develop criteria to determine the basis on which waivers of the 20% matching fund requirement may be provided. One option for doing so is for the Agency to establish a single waiver standard, such as per capita income, to identify recipients with financial need. In the school asbestos program, for example, EPA measures financial need as a function of per capita income in the school district. A second option would be for the Agency to use a set of criteria, instead of a single measure, to determine financial need. Possible criteria might include a combination of such measures as per capita income, median household income, and demonstrated efforts to raise funds and in-kind contributions from State and local governments as well as private citizens. A third option might be simply to allow groups the opportunity to present whatever evidence of financial need they deem relevant in their waiver application. In addition, EPA could decide to grant partial waivers to groups able to raise part, but not all, of the 20 percent contribution.

The Agency seeks comments on the criteria for determining financial need, and on the process that EPA should consider using to determine if waivers to the 20 percent match requirement should be granted.

Waivers of the $50,000 Limit on Grants

Section 117(e) states that "The amount of any grant under this subsection may not exceed $50,000 for a single grant recipient. The President may waive the $50,000 limitation in any case where such waiver is necessary to carry out the purposes of this subsection." The Agency must determine under what circumstances a waiver to the $50,000 limit on grants may be given.

The Agency might issue waivers only for sites that are deemed significantly more technologically complex than a "typical" remedial action. Indicators of complexity might include unusual waste type or hydrogeology. Alternatively, the Agency might issue waivers only at sites where unanticipated changes in the remedial action justify a need for additional technical assistance. EPA also could issue waivers to single grant applicants representing groups from several NPL sites in close proximity. The technical assistance grants award could not exceed the sum of the maximum allowable amount for the individual sites involved.

The Agency solicits comments on these or other criteria that would provide reasonable guidelines for

determining when and on what basis to grant waivers of the $50,000 limit.

Other

The Agency is particularly interested in receiving comments regarding the types of assistance communities may desire, such as training or guidance manuals, to enable them to participate fully in the program.

Another issue on which the Agency seeks comments is disclosure and avoidance of potential conflict of interests. Given the limited pool of technically qualified individuals or firms available to interpret information concerning Superfund actions, some may have worked for potentially responsible parties or have been or will be involved in litigation against the Agency. 40 CFR Parts 30 and 33 contain sections pertaining to conflict of interests. What additional requirements, if any, should the Agency impose to ensure that potential conflict of intertest does not impede the effectiveness of the technical advisers? For example, should EPA require prospective technical advisers to disclose in their proposals all financial and business relationships with any potentially responsible parties at Superfund sites so that the grantee can determine if it wants to select that technical adviser? In addition, should the technical advisers be required to inform the citizen group responsible for the grant, EPA, the State, and other interested parties, if they are invited to provide services related to any proposed or pending litigation concerning or arising from the site after award of the grant?

Conclusion

Although EPA is asking commenters to direct their remarks toward the issues identified in this ANRM, the Agency welcomes comments regarding other aspects of the technical assistance grant program.

Dated: June 2, 1987.

Lee M. Thomas,

Administrator.

Appendix—Summary of EPA Grant and Procurement Regulations

Two existing EPA regulations—"General Regulations for Assistance Programs" (40 CFR Part 30) and "Procurement under Assistance Agreements" (40 CFR Part 33) form the basis of the requirements of the Technical Assistance Grant program.

The first of these regulations, entitled "General Regulations for Assistance Programs" (40 CFR Part 30), outlines the procedures of requirements for applying for and managing an assistance agreement with EPA. The second, "Procurement Under Assistance Agreements" (40 CFR Part 33) defines specific requirements that a group must follow when spending money obtained under an assistance agreement. The following paragraphs provide a summary of these regulations.

"General Regulations for Assistance Programs" (40 CFR Part 30)

In Subpart C of 40 CFR Part 30, EPA outlines both the types of activities and the types of groups or individuals who are eligible to receive assistance. Specific requirements outlined in this section are:

- Timeliness for project completion;
- Guidelines for cost sharing between the grant applicant and EPA; and
- The responsibilities that are assumed by the grant applicant once an assistance agreement is accepted.

The financial requirements of the technical assistance grant program are based upon Subparts D and E of 40 CFR Part 30. These regulations establish the EPA standards that will be required under the technical assistance program for releasing funds to citizen groups, determining allowable costs, and managing project finances. Also presented in these sections are the requirements for the maintenance and management of financial records and scientific data, constraints and allowance for financial management, and the procedures for EPA audits of groups receiving funds.

Subpart F of 40 CFR Part 30 specifies the applicable Federal laws and policies that affect an assistance agreement between any Federal agency and a grant recipient. This subpart also defines the restrictions on the use of assistance funds for advocacy purposes and states EPA's policy on conflict of interest.

Subpart H of 40 CFR Part 30 lists the requirements with which grant applicants must comply in keeping records and submitting reports upon completion of the project.

Subpart I of 40 CFR Part 30 stipulates both the enforcement that a Federal agency may take to ensure that grant recipients comply with all of the terms and conditions of an assistance agreement, and the consequences of non-compliance with all of these terms and conditions. Subpart L outlines procedures for resolving disputes with EPA officials concerning the terms and conditions of an assistance agreement.

"Procurement Under Assistance Agreements" (40 CFR Part 33)

This regulation gives requirements with which the grant recipients must comply before any grant money can be spent. This regulation applies to all recipients of EPA assistance agreements, including technical assistance grant recipients.

Under Subpart B, "Procurement Requirements" the grant recipient is responsible for complying with the requirements for hiring and overseeing contractors. In particular, this subpart presents requirements regarding competition; grant recipient responsibilities in assessing a fair profit for the contract; the use of small, minority, women's and labor surplus area businesses; and the need for accuracy in documenting and specifying the procurement request. Also, this subpart states that recipients must formulate and follow a code of conduct in the assessing and awarding of subagreements. When obtaining a contractor, the grant recipient must follow the guidelines set out in the subpart on advertising bids and proposals, competitive negotiation, and non-competitive negotiation.

[FR Doc. 87-12963 Filed 6-9-87; 8:45am]

BILLING CODE 6560-50-M

Federal Register

Wednesday
June 10, 1987

Part VI

Department of Education

34 CFR Part 99

Family Educational Rights and Privacy; Notice of Proposed Rulemaking

DEPARTMENT OF EDUCATION

34 CFR Part 99

Family Educational Rights and Privacy

AGENCY: Department of Education.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Secretary proposes to revise and rename the Department of Education (ED) regulations presently titled the Privacy Rights of Parents and Students. These proposed regulations will be retitled Family Educational Rights and Privacy and will eliminate some of the regulatory requirements placed on the schools. The regulations have also been rewritten for clarity.

DATES: Comments must be received on or before August 10, 1987.

ADDRESSES: All comments concerning these proposed regulations should be addressed to Patricia Ballinger, Student and Family Education Rights and Privacy Office, U.S. Department of Education, 400 Maryland Avenue, SW., Washington, DC 20202.

A copy of any comments that concern information collection requirements should also be sent to the Office of Management and Budget at the address listed in the Paperwork Reduction Act section of this preamble.

FOR FURTHER INFORMATION CONTACT: Patricia Ballinger. Telephone (202) 732-2058.

SUPPLEMENTARY INFORMATION:

Background

Under Executive Order 12291, the Department of Education regularly reviews its regulations to determine whether the Department can decrease burdens on the public and otherwise simplify and clarify existing regulations. As part of this process, the Department has reviewed the regulations implementing the Family Educational Rights and Privacy Act (FERPA).

The FERPA regulations of the Department of Health, Education, and Welfare (HEW) (45 CFR Part 99), among other regulations, were transferred to the Department of Education (ED) and recodified in Part 99 of Title 34 of the Code of Federal Regulations on May 9, 1980 (45 FR 30802). These regulations implement FERPA, which was enacted as Section 438 of the General Education Provisions Act (GEPA). (20 U.S.C. 1232g)

The Family Educational Rights and Privacy Act sets out requirements designed to protect the privacy of parents and students. Specifically, the statute applies to education records maintained by educational agencies and institutions at which students are or have been in attendance. In brief, the statute requires those agencies or institutions to provide parents and students access to records directly related to the students; to permit parents and students to challenge those records on the grounds that they are inaccurate, misleading, or otherwise in violation of the students' privacy or other rights; to obtain the written consent of parents or students before releasing personally identifiable information about the students to other than organizations or individuals described in a specified list of exceptions; and to notify parents or students of these rights.

Changes Proposed in the Regulations

In the process of revising the current regulations, numerous changes have been made to simplify and clarify the regulations. The Secretary does not intend those changes to alter any interpretation under existing regulations.

The following changes are noted for the benefit of the reader:

1. (a) The Secretary proposes to change the title of the regulations to Family Educational Rights and Privacy, to follow more closely the title of the Act.

(b) The Secretary proposes to add a note following § 99.2 to reference the Department's regulations concerning the requirement of confidentiality of information relating to handicapped children who receive benefits under the Education of the Handicapped Act.

2. In § 99.3, the following changes are proposed—

(a) The Secretary is considering establishment of a further standard to assist in determining whether information may be classified as "directory information," and therefore released without obtaining prior consent by a parent or student. In the current regulations, the nonstatutory phrase "and other similar information," which appears at the end of the list of items of directory information, is used to indicate that certain other information may be included as directory information. However, the current regulations set no standard for interpreting that phrase. The Secretary proposes to delete the nonstatutory phrase and to include the following language at the beginning of the definition of "directory information": "'Directory information' means information contained in an education record of a student which would not generally be considered harmful or an invasion of privacy if disclosed. It includes, but is not limited to, the kinds of information contained in yearbooks, student directories, and sports programs. The following are examples of information that may be designated as directory information: . . ." The Secretary particularly invites comments on whether it would be helpful to include this standard as part of the definition of "directory information."

(b) The last sentence in the definition of "educational institution," regarding applicability, would be moved to § 99.1(d), where it more logically fits.

(c) In the definition of "education records," paragraph (b)(1)(ii) of the current regulations defines the term "substitute." The proposed regulations would replace that definition with the phrase "temporary substitute for the maker of the record." In paragraph (b)(4), the current regulations use the word "created" instead of the statutory word "made." In an effort to simplify the regulations, the Secretary proposes to return to the statutory language. The provision at paragraph (b)(4)(iii) of the current regulations regarding student access would be moved to § 99.11(f), where it more logically fits.

(d) In the definition of "education records," paragraph (b)(5), the nonstatutory example in the current regulations, would be deleted because experience indicates that the exclusion is sufficiently clear without the example.

(e) The definition of "financial aid" in the current regulations would be moved to proposed § 99.31(a)(4)(ii) where it more logically fits.

(f) In the proposed definition of "parent," the Secretary has added the term "of a student", which clarifies that the parent referred to is the parent of the student whose records are maintained by the school. This eliminates the need to refer to "the parent of the student" or "his or her parent" throughout the regulations. The second sentence in the definition of "parent" in the current regulations, concerning the presumption that the parent has authority to exercise rights, would be moved to a proposed new § 99.4, which describes parents' rights under the Act. Existing §§ 99.11(c) and 99.30(b), which also contain the presumption, would be deleted as unnecessary.

(g) The proposed definition of "personally identifiable information" would be changed to include the address of the student's family, since in many cases that address can be used to locate the student.

(h) The Secretary proposes to revise the definition of "Secretary" to make it consistent with the definition contained in the Education Department General Administrative Regulations (See 34 CFR 77.1(c)).

(i) The Secretary proposes to change the definition of "student" to include

former students, which makes clear that most rights accorded students by this Act also apply to former students. Section 99.1(d) of the current regulations would be deleted as unnecessary. Sections 99.7(a) and 99.37(a) would be revised to clarify that an educational agency or institution need provide notification only to parents of students currently in attendance and to eligible students currently in attendance. Paragraph (b) of the definition of "student" in the current regulations, which concerns a student's application for admission to a postsecondary institution, would be moved to § 99.5(c) where it more logically fits. The example provided in the second sentence of paragraph (b) of the current regulations would be deleted as unnecessary.

3. (a) The Secretary proposes to delete § 99.4(b) in the current regulations because it is redundant with § 99.31(a)(8). There is no intent to change the interpretation that eligible students (students 18 years of age or older or who attend an institution of postsecondary education) have all the rights accorded by the Act even though they may be a dependent of their parents.

(b) Section 99.4 of the current regulations would be renumbered as § 99.5.

4. The Secretary does not propose any substantive changes in § 99.5 relating to the written policy each agency and institution must adopt. However, the section (renumbered as § 99.6) has been rewritten to improve its clarity.

5. (a) The Secretary wishes to clarify that the annual notification described in § 99.6 of the current regulations requires an educational agency or institution to provide parents or eligible students a brief statement of their rights. An agency or institution has the option of using any means of notification which is reasonably likely to inform parents or eligible students of their rights. Annual notification does not have to include the student records policy adopted under proposed § 99.6. However, the statement must indicate the places where copies of the policy are kept and where a parent or eligible student may obtain upon request a copy of the policy.

(b) Section 99.6 of the current regulations would be renumbered as § 99.7.

6. (a) The Secretary proposes to delete the nonstatutory general waiver provision in § 99.7 (a), (b), and (e) of the current regulations. FERPA establishes a limited waiver provision that permits a student to waive his or her right to inspect and review a certain class of education records under a narrow set of circumstances. In return, the educational agency or institution that receives the waiver must meet certain additional requirements regarding those education records. The proposed regulations do not cover the nonstatutory possibilities for waiver. However, the Secretary does not intend to forbid nonstatutory waivers as provided in the current regulations under § 99.7 (a), (b), and (e).

(b) Given the Secretary's interpretation of the statute that parents may not waive students' rights under the statutory waiver provision, the Secretary proposes to delete as unnecessary § 99.7(f)(3) of the current regulations which specifies that an eligible student may revoke a waiver signed by a parent.

(c) The remaining paragraphs of § 99.7 in the current regulations are incorporated in § 99.12 of the proposed regulations.

7. Section 99.8 of the current regulations would be rewritten for clarity and would be renumbered as § 99.11.

8. In the last sentence of § 99.11(a) of the current regulations concerning the time within which an educational agency or institution must respond to a request from a parent or student to inspect the student's education records, the Secretary proposes to change the language to read "after it has received the request" to be consistent with § 99.22(a). This proposed change will clarify for the first time that the 45-day period will start when the request for access is received by the agency or institution. The section would be renumbered as § 99.10.

9. (a) The Secretary proposes to delete the nonstatutory requirement for documentation in § 99.12(a)(2)(i) of the current regulations because it imposes an unreasonable burden on an educational agency or institution to try to obtain a written statement that letters of recommendation placed in education records prior to January 1, 1975 were understood to be confidential.

(b) The Secretary proposes to revise the title of this section to reflect the fact that it contains some requirements that apply to all educational agencies and institutions.

10. In § 99.13 of the current regulations, paragraph (a) has been renumbered as proposed § 99.11(e); paragraph (b) has been renumbered as proposed § 99.21(c)(1); and paragraph (c) has been renumber as proposed § 99.32(a)(2).

11. Section 99.30(a)(2) of the current regulations would be moved to § 99.31(a)(12), where it more logically fits.

12. (a) In § 99.31(a)(2), the Secretary proposes to add language to clarify that "schools" include institutions of postsecondary education.

(b) Section 99.31(a)(3)(iii) codifies an amendment to the Act which permits access by local educational authorities. (20 U.S.C. 1232g (b)(3))

(c) In § 99.31(a)(5), the language in the current regulation that reinforces the distinction between disclosures "required" and disclosures "permitted" under State statute would be deleted as an unnecessary explanation of a clear mandate.

(d) The Secretary proposes to add § 99.31(a)(11) to complete the list of situations where consent is not required before disclosing an education record.

13. The Secretary proposes to move the proviso regarding recordkeeping requirements at § 99.33(b) in the current regulations to a new paragraph, § 99.32(b), where it more logically fits. The new provision clarifies that if an educational agency or institution discloses information under the conditions set forth in § 99.33(b), the record of disclosure which it is required to maintain must include the names of the additional parties to whom the receiving party may disclose, and the legitimate interests each additional party may have in obtaining the information.

14. (a) Section 99.33(b) is re-written in order to clarfiy that an educational agency or institution that discloses information uder § 99.31 may have an understanding with the party receiving the information that it may make further disclosures on behalf of the agency or institution. Under this understanding, the receiving party may make these disclosures if the recordkeeping requirements of § 99.32(b) have been met and the disclosures meet the requirements of § 99.31.

(b) In § 99.31(c) of the proposed regulations, the Secretary has added language to clarify that the redisclosure limitation does not apply to parents or students, inasmuch as the statute refers to disclosures to "third parties" and students and their parents are not considered "third parties" with respect to the students' own records.

15. Proposed § 99.35 codifies an amendment to the Act which permits access to records by local educational authorities and permits disclosure without consent for State as well as Federal programs. (20 U.S.C. 1232g(b)(3))

16. Proposed § 99.36 would delete a provision presently in § 99.36(b) that describes the considerations appropriate in determining whether an emergency exists that warrents disclosure without prior consent. The Secretary believes that this provision is unnecessary

because educational agencies and institutions are capable of making these determinations without the need for a federal regulation.

17. (a) In proposed § 99.60(a), the Secretary has added language to define "Office" as the Student and Family Education Rights and Privacy Office.

(b) Existing § 99.60(a)(2) would be revised to make clear that the Office not only investigates complaints, but provides assistance to agencies and institutions regarding proper compliance with the Act. Historically, this has been a function of the Office as administered by the Department of Education and its predecessor, the Department of Health, Education, and Welfare. The Secretary believes the public should be made aware of this service through the regulations.

(c) Under the General Education Provisions Act (GEPA), Section 451(a), the Secretary has discretion to designate the Education Appeal Board (EAB) to hear cases involving disputes under programs administered by the Secretary. The Secretary proposes to designate the EAB to conduct hearings required under Subpart E of these regulations.

18. (a) Section 99.62 has been revised to delete the recordkeeping requirement. This requirement proposed for deletion is unnecessary because the Education Department General Administrative Regulations (EDGAR) already impose the requirement on grantees of the Department under § 437(a) of the General Education Provisions Act (20 U.S.C. 1232f(a)), see EDGAR §§ 75.730–75.734 and 76.730–76.734. In addition, Part 74 of EDGAR provides general rules about maintenance of records.

(b) The Secretary proposes to change the language in § 99.62 from "afford access" to "submit reports," which will more accurately reflect the kind of investigation conducted by the Office. Since its inception, the Office has not conducted any on-site visits to resolve complaints; rather, it has resolved complaints through correspondence and telephone calls with the affected parties. The Department does not foresee a need to inspect records on the premises.

19. Existing § 99.67 has been rewritten to designate the Education Appeal Board as the reviewing authority for compliance issues under FERPA. The procedures used by the EAB are in 34 CFR Part 78, and would be applicable to any enforcement actions under FERPA. The remedies of withholding and cease and desist are governed by Part E of the General Education Provisions Act (20 U.S.C. 1234b and 1234c), and would be available to the extent provided for by that Act.

20. A Distribution Table is appended as a guide to where sections in the current regulations are located in the proposed regulations.

Executive Order 12291

These proposed regulations have been reviewed in accordance with Executive Order 12291. They are not classified as major because they do not meet the criteria for major regulations established in the Order.

Regulatory Flexibility Act Certification

The Secretary certifies that the regulations will not have a significant economic impact on a substantial number of small entities. Although these proposed regulations will affect a substantial number of small entities receiving funds under programs administered by the Secretary of Education, they impose minimal requirements. The proposed regulations are intended to give educational agencies and institutions wide latitude in fulfilling statutory requirements. The only recordkeeping requirement (Section 99.32) is mandated by statute and imposes a minimal economic impact on an agency or institution. These regulations also propose to remove some existing requirements (see Changes Proposed in these Regulations, paragraph 6), thereby further reducing the burden imposed on schools.

Paperwork Reduction Act of 1980

Sections 99.6, 99.7 and 99.32 contain information collection requirements. As required by section 3504(h) of the Paperwork Reduction Act of 1980, the Department of Education will submit a copy of this regulation to the Office of Management and Budget (OMB) for its review. Organizations and individuals desiring to submit comments on the information collection requirements should direct them to the Office of Information and Regulatory Affairs, OMB, Room 3002, New Executive Office Building, Washington, DC 20503; Attention: Joseph F. Lackey, Jr.

Invitation to Comment

Interested persons are invited to submit comments and recommendations regarding these proposed regulations.

All comments submitted in response to these proposed regulations will be available for public inspection, during and after the comment period, in Room 3021, 400 Maryland Avenue, SW, Washington, DC, between the hours of 8:30 a.m. and 4:00 p.m., Monday through Friday of each week except Federal holidays.

To assist the Department in complying with the specific requirements of Executive Order 12291 and the Paperwork Reduction Act of 1980 and their overall requirement of reducing regulatory burden, public comment is invited on whether there may be further opportunities to reduce any regulatory burdens found in these proposed regulations.

Assessment of Educational Impact

The Secretary particularly requests comments on whether the regulations in this document would require transmission of information that is being gathered by or is available from any other agency or authority of the United States.

List of Subjects in 34 CFR Part 99

Administrative practice and procedure, Education department, Family educational rights, Privacy, Parents, Reporting and recordkeeping requirements, Students.

Citation of Legal Authority:

A citation of statutory or other legal authority is placed in parentheses on the line following each substantive provision of these proposed regulations.

Dated: June 5, 1987.

William J. Bennett,

Secretary of Education.

(Catalog of Federal Domestic Assistance number does not apply)

The Secretary proposes to revise Part 99 of Title 34 of the Code of Federal Regulations to read as follows:

PART 99—FAMILY EDUCATIONAL RIGHTS AND PRIVACY

Subpart A—General

Sec.

Subpart B—What are the Rights of Inspection and Review of Education Records?

Authority: Section 438, Pub. L. 90-247, Title IV, as amended, 88 Stat. 571-574 (20 U.S.C. 1232g), unless otherwise noted.

Subpart A—General

§ 99.1 To which educational agencies or institutions do these regulations apply?

(a) This part applies to an educational agency or institution to which funds have been made available under any program administered by the Secretary of Education that—

(1)(i) Was transferred to the Department under the Department of Education Organization Act (DEOA); and

(ii) Was administered by the Commissioner of Education on the day before the effective date of the DEOA; or

(2) Was enacted after the effective date of the DEOA, unless the law enacting the new Federal program has the effect of making Section 438 of the General Education Provisions Act inapplicable.

(20 U.S.C. 1230, 1232g, 3487, 31507)

(b) The following chart lists the funded programs to which Part 99 does not apply as of June 5, 1987.

Name of program	Authorizing statute	Implementing regulations
1. High School Equivalency Program and College Assistance Migrant Program.	Section 418A of the Higher Education Act of 1965 as amended by the Education Amendments of 1980 (Pub. L. 96-374) 20 U.S.C. 1070d-2).	Part 206.
2. Programs administered by the Commissioner of the Rehabilitative Services Administration, and the Director of the National Institute on Disability and Rehabilitation Research.	The Rehabilitation Act of 1973, as amended. (29 U.S.C. 700, et seq.).	Parts 350-359, 361, 365, 366, 369-371, 373-375, 378, 379, 385-390, and 395.
3. Transition program for refugee children.	Immigration and Nationality Act, as amended by the Refugee Act of 1980, Pub. L. 96-212 (8 U.S.C. 1522(d)).	Part 538.
4. College Housing.	Title IV of the Housing Act of 1950, as amended (12 U.S.C. 1749, et seq.).	Part 614.
5. The following programs administered by the Assistant Secretary for Educational Research and Improvement: Educational Research Grant Program. Regional Educational Laboratories. Research and Development Centers. All other research or statistical activities funded under Section 405 or 406 of the General Education Provisions Act.	Section 405 of the General Education Provisions Act (20 U.S.C. 1221e), and section 406 of the General Education Provisions Act (20 U.S.C. 1221-1).	Parts 700, 706-708.

Note: The Secretary, as appropriate, updates the information in this chart and informs the public.

(c) This part does not apply to an educational agency or institution solely because students attending that agency or institution receive non-monetary benefits under a program referenced in paragraph (a) of this section, if no funds under that program are made available to the agency or institution.

(d) The Secretary considers funds to be made available to an educational agency or institution if funds under one or more of the programs referenced in paragraph (a) of this section—

(1) Are provided to the agency or institution by grant, cooperative agreement, contract, subgrant, or subcontract; or

(2) Are provided to students attending the agency or institution and the funds may be paid to the agency or institution by those students for educational purposes, such as under the Pell Grant Program and the Guaranteed Student Loan Program (Titles IV-A-1 and IV-B, respectively, of the Higher Education Act of 1965, as amended).

(e) If an educational agency or institution receives funds under one or more of the programs covered by this section, the regulations in this part apply to the recipient as a whole, including each of its components (such as a department within a university).

(20 U.S.C. 1232g)

§ 99.2 What is the purpose of these regulations?

The purpose of this part is to set out requirements for the protection of privacy of parents and students under section 438 of the General Education Provisions Act, as amended.

(20 U.S.C. 1232g)

Note: 34 CFR § 300.560-§ 300.576 contain requirements regarding confidentiality of information relating to handicapped children who receive benefits under the Education of the Handicapped Act.

§ 99.3 What definitions apply to these regulations?

The following definitions apply to this part:

"Act" means the Family Educational Rights and Privacy Act of 1974, enacted as section 438 of the General Education Provisions Act.

(20 U.S.C. 1232g)

"Attendance" includes, but is not limited to—

(a) Attendance in person or by correspondence; and

(B) The period during which a person is working under a work-study program.

(20 U.S.C. 1232g)

"Directory information" means information contained in an education record of a student which would not generally be considered harmful or an invasion of privacy if disclosed. It includes, but is not limited to, the student's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received, and the most recent previous educational agency or institution attended.

(20 U.S.C. 1232g(a)(5)(A))

"Disclosure" means to permit access to or the release, transfer, or other communication of education records, or the personally identifiable information contained in those records, to any party, by any means, including oral, written, or electronic means.

(20 U.S.C. 1232g(b)(1))

"Educational agency or institution" means any public or private agency or institution to which this part applies under § 99.1(a).

(20 U.S.C. 1232g(a)(3))

"Education records" (a) The term means those records that are—

(1) Directly related to a student; and

(2) Maintained by an educational agency or institution or by a party acting for the agency or institution.

(b) The term does not include—

(1) Records of instructional, supervisory, and administrative personnel and educational personnel ancillary to those persons that are kept in the sole possession of the maker of the record, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record;

(2) Records of a law enforcement unit of an educational agency or institution, but only if education records maintained by the agency or institution are not disclosed to the unit, and the law enforcement records are—

(i) Maintained separately from education records;

(ii) Maintained solely for law enforcement purposes; and

(iii) Disclosed only to law enforcement officials of the same jurisdiction;

(3)(i) Records relating to an individual who is employed by an educational agency or institution, that—

(A) Are made and maintained in the normal course of business;

(B) Relate exclusively to the individual in that individual's capacity as an employee; and

(C) Are not available for use for any other purpose.

(ii) Paragraph (b)(3)(i) of this definition does not apply to records relating to an individual in attendance at the agency or institution who is employed as a result of his or her status as a student;

(4) Records on a student who is 18 years of age or older, or is attending an institution of postsecondary education, that are—

(i) Made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his or her professional capacity or assisting in a paraprofessional capacity;

(ii) Made, maintained, or used only in connection with treatment of the student; and

(iii) Disclosed only to individuals providing the treatment. For the purpose of this definition, "treatment" does not include remedial educational activities or activities that are part of the program of instruction at the agency or institution; and

(5) Records that only contain information about an individual after he or she is not longer a student at that agency or institution.

(20) U.S.C. 1232g(a)(4))

"Eligible student" means a student who has reached 18 years of age or is attending an institution of postsecondary education.

(20 U.S.C. 1232g(d))

"Institution of postsecondary education" means an institution that provides education to students beyond the secondary school level; "secondary school level" means the educational level (not beyond grade 12) at which secondary education is provided as determined under State law.

(20 U.S.C. 1232g(d))

"Parent" means a parent of a student and includes a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian.

(20 U.S.C. 1232g)

"Party" means an individual, agency, instutition, or organization.

(20 U.S.C. 1232g(b)(4)(A))

"Personally identifiable information" includes, but is not limited to—

(a) The student's name;

(b) The name of the student's parent or other family member;

(c) The address of the student or student's family;

(d) A personal identifier, such as the student's social security number or student number;

(e) A list of personal characteristics that would make the student's identity easily traceable; or

(f) Other information that would make the student's identity easily traceable.

(20 U.S.C. 1232g)

"Record" means any information recorded in any way, including, but not limited to, handwriting, print, tape, film, microfilm, and microfiche.

(20 U.S.C. 1232g)

"Secretary" means the Secretary of the U.S. Department of Education or an official or employee of the Department of Education acting for the Secretary under a delegation of authority.

(20 U.S.C. 1232g)

"Student", except as otherwise specifically provided in this part, means any individual who is or has been in attendance at an educational agency or institution and regarding whom the agency or institution maintains education records.

(20 U.S.C. 1232g(a)(6))

§ 99.4 What are the rights of parents?

An educational agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation, or custody that specifically revokes these rights.

(20 U.S.C. 1232g)

§ 99.5 What are the rights of eligible students?

(a) When a student becomes an eligible student, the rights accorded to, and consent required of, his or her parent under this part transfer from the parent to the student.

(b) The Act and this part do not prevent educational agencies or institutions from giving students rights in addition to those given to parents of students.

(c) If an individual has attended one component of an educational agency or institution, that attendance does not give the individual rights as a student in other components of the agency or institution at which the individual has never been in attendance.

(20 U.S.C. 1232g(d))

§ 99.6 What information must an educational agency's or institution's policy contain?

(a) Each educational agency or institution shall adopt a policy regarding how the agency or institution meets the requirements of the Act and of this part. The policy must include—

(1) How the agency or institution informs parents and students of their rights, in accord with §99.7;

(2) How a parent or eligible student may inspect and review education records under §99.10, including at least—

(i) The procedure the parent or eligible student must follow to inspect and review the records;

(ii) With an understanding that it may not deny access to education records, a description of the circumstances in which the agency or institution believes it has a legitimate cause to deny a request for a copy of those records;

(iii) A schedule of fees (if any) to be charged for copies; and

(iv) A list of the types and locations of education records maintained by the agency or institution, and the titles and addresses of the officials responsible for the records;

(3) A statement that personally identifiable information will not be released from an education record without the prior written consent of the parent or eligible student, except under one or more of the conditions described in §99.31;

(4) A statement indicating whether the educational agency or institution has a policy of disclosing personally identifiable information under §99.31(a)(1), and, if so, a specification of the criteria for determining which parties are school officials and what the agency or institution considers to be a legitimate educational interest;

(5) A statement that a record of disclosures will be maintained as required by §99.32, and that a parent or eligible student may inspect and review that record;

(6) A specification of the types of personally identifiable information the agency or institution has designated as directory information under §99.37; and

(7) A statement that the agency or institution permits a parent or eligible student to request correction of the student's education records under §99.20, to obtain a hearing under §99.21(a), and to add a statement to the record under §99.21(b)(2).

(b) The educational agency or institution shall state the policy in writing and make a copy of it available on request to a parent or eligible student.

(20 U.S.C. 1232g(e) and (f))

§99.7 What must an educational agency or institution include in its annual notification?

(a) Each educational agency or institution shall annually notify parents of students currently in attendance, and eligible students currently in attendance, at the agency or institution of their rights under the Act and this part. The notice must include a statement that the parent or eligible student has a right to—

(1) Inspect and review the student's education records;

(2) Request the amendment of the student's education records to ensure that they are not inaccurate, misleading, or otherwise in violation of the student's privacy or other rights;

(3) Consent to disclosures of personally identifiable information contained in the student's education records, except to the extent that the Act and the regulations in this part authorize disclosure without consent;

(4) File with the U. S. Department of Education a complaint under §99.64 concerning alleged failures by the agency or institution to comply with the requirements of the Act and this part; and

(5) Obtain a copy of the policy adopted under §99.6.

(b) The notice provided under paragraph (a) of this section must also indicate the places where copies of the policy adopted under §99.6 are located.

(c) An educational agency or institution may provide this notice by any means that are reasonably likely to inform the parents and eligible students of their rights.

(d) An agency or institution of elementary or secondary education shall effectively notify parents of students who have a primary or home language other than English.

(20 U.S.C. 1232g(e))

Subpart B—What are the Rights of Inspection and Review of Education Records?

§ 99.10 What rights exist for a parent or eligible student to inspect and review education records?

(a) Except as limited under § 99.12, each educational agency or institution shall permit a parent or eligible student to inspect and review the education records of the student.

(b) The educational agency or institution shall comply with a request for access to records within a reasonable period of time, but in no case more than 45 days after it has received the request.

(c) The educational agency or institution shall respond to reasonable requests for explanations and interpretations of the records.

(d) The educational agency or institution shall give the parent or eligible student a copy of the records if failure to do so would effectively prevent the parent or student from exercising the right to inspect and review the records.

(e) The educational agency or institution shall not destroy any education records if there is an outstanding request to inspect and review the records under this section.

(f) While an educational agency or institution is not required to give an eligible student access to treatment records under paragraph (b)(4) of the

definition of "Education records" in § 99.3, the student may have those records reviewed by a physician or other appropriate professional of the student's choice.

(20 U.S.C. 1232g(a)(1)(A))

§ 99.11 May an educational agency or institution charge a fee for copies of education records?

(a) Unless the imposition of a fee effectively prevents a parent or eligible student from exercising the right to inspect and review the student's education records, an educational agency or institution may charge a fee for a copy of an education record which is made for the parent or eligible student.

(b) An educational agency or institution may not charge a fee to search for or to retrieve the education records of a student.

(20 U.S.C. 1232g(a)(1))

§ 99.12 What limitations exist on the right to inspect and review records?

(a) If the education records of a student contain information on more than one student, the parent or eligible student may inspect, review, or be informed of only the specific information about that student.

(b) A postsecondary institution does not have to permit a student to inspect and review education records that are—

(1) Financial records, including any information those records contain, of his or her parents;

(2) Confidential letters and confidential statements of recommendation placed in the education records of the student before January 1, 1975, as long as the statements are used only for the purposes for which they were specifically intended; and

(3) Confidential letters and confidential statements of recommendation placed in the student's education records after January 1, 1975, if—

(i) The student has waived his or her right to inspect and review those letters and statements; and

(ii) Those letters and statements are related to the student's—

(A) Admission to an educational institution;

(B) Application for employment; or

(C) Receipt of an honor or honorary recognition.

(c)(1) A waiver under paragraph (b)(3)(i) of this section is valid only if—

(i) The educational agency or institution does not require the waiver as a condition for admission to or receipt of a service or benefit from the agency or institution; and

(ii) The waiver is made in writing and signed by the student, regardless of age.

(2) If a student has waived his or her rights under paragraph (b)(3)(i) of this section, the educatonal institution shall—

(i) Give the student, on request, the names of the individuals who provided the letters and statements of recommendation; and

(ii) Use the letters and statements of recommendation only for the purpose for which they were intended.

(3)(i) A waiver under paragraph (b)(3)(i) of this section may be revoked with respect to any actions occurring after the revocation.

(ii) A revocation under paragraph (c)(3)(i) of this section must be in writing.

(20 U.S.C. 1232g(a)(1)(A) and (B))

Subpart C—What are the Procedures for Amending Education Records?

§ 99.20 How can a parent or eligible student request amendment of the student's education records?

(a) If a parent or eligible student believes the education records relating to the student contain information that is inaccurate, misleading, or in violation of the student's rights of privacy or other rights, he or she may ask the educational agency or institution to amend the record.

(b) The educational agency or institution shall decide whether to amend the record as requested within a reasonable time after the agency or institution receives the request.

(c) If the educational agency or institution decides not to amend the record as requested, it shall inform the parent or eligible student of its decision and of his or her right to a hearing under § 99.21

(20 U.S.C. 1232g(a)(2))

§ 99.21 Under what conditions does a parent or eligible student have the right to a hearing?

(a) An educational agency or institution shall give a parent or eligible student, on request, an opportunity for a hearing to challenge the content of the student's education records on the grounds that the information contained in the education records is inaccurate, misleading, or in violation of the privacy or other rights of the student.

(b)(1) If, as a result of the hearing, the educational agency or institution decides that the information is inaccurate, misleading, or otherwise in violation of the privacy or other rights of the student, it shall—

(i) Amend the record accordingly; and

(ii) Inform the parents or eligible student of the amendment in writing.

(2) If, as a result of the hearing, the educational agency or institution decides that the information in the education record is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the student, it shall inform the parent or eligible student of the right to place a statement in the record commenting on the contested information in the record or stating why he or she disagrees with the decision of the agency or institution, or both.

(c) If an educational agency or institution places a statement in the education records of a student under paragraph (b)(2) of this section, the agency or institution shall—

(1) Maintain the statement with the contested part of the record for as long as the record is maintained; and

(2) Disclose the statement whenever it discloses the portion of the record to which the statement relates.

(20 U.S.C. 1232g(a)(2))

§ 99.22 What minimum requirements exist for the conduct of a hearing?

The hearing required by § 99.21 must meet, at a minimum, the following requirements:

(a) The educational agency or institution shall hold the hearing within a reasonable time after it has received the request for the hearing from the parent or eligible student.

(b) The educational agency or institution shall give the parent or eligible student notice of the date, time, and place, reasonably in advance of the hearing.

(c) The hearing may be conducted by any individual, including an official of the educational agency or institution, who does not have a direct interest in the outcome of the hearing.

(d) The educational agency or institution shall give the parent or eligible student a full and fair opportunity to present evidence relevant to the issue raised under § 99.21. The parent or eligible student may, at their own expense, be assisted or represented by one or more individuals of his or her own choice, including an attorney.

(e) The educational agency or institution shall make its decision in writing within a reasonable period of time after the hearing.

(f) The decision must be based solely on the evidence presented at the hearing, and must include a summary of the evidence and the reasons for the decision.

(20 U.S.C. 1232g(a)(2))

Subpart D—May an Educational Agency or Institution Disclose Personally Identifiable Information from Education Records?

§ 99.30 Under what conditions must an educational agency or institution obtain prior consent to disclose information?

(a) Except as provided in § 99.31, an educational agency or institution shall obtain a signed and dated written consent of a parent or an eligible student before it discloses personally identifiable information from the student's education records.

(b) The written consent must—

(1) Specify the records that may be disclosed;

(2) State the purpose of the disclosure; and

(3) Identify the party or class of parties to whom the disclosure may be made.

(c) When a disclosure is made under paragraph (a) of this section—

(1) If the parent or eligible student so requests, the educational agency or institution shall provide him or her with a copy of the records disclosed; and

(2) If the parent of a student who is not an eligible student so requests, the agency or institution shall provide the student with a copy of the records disclosed.

(20 U.S.C. 1232g(b)(1) and (b)(2)(A))

§ 99.31 Under what conditions is prior consent not required to disclose information?

(a) An educational agency or institution may disclose personally identifiable information from an education record of a student without the consent required by § 99.30 if the disclosure meets one or more of the following conditions:

(1) The disclosure is to other school officials, including teachers, within the agency or institution whom the agency or institution has determined to have legitimate educational interests.

(2) The disclosure is, subject to the requirements of § 99.34, to officials of another school, school system, or institution of postsecondary education where the student seeks or intends to enroll.

(3) The disclosure is, subject to the requirements of § 99.35, to authorized representatives of—

(i) The Comptroller General of the United States;

(ii) The Secretary; or

(iii) State and local educational authorities.

(4)(i) The disclosure is in connection with financial aid for which the student has applied or has received, if the information is necessary for such purposes as to—

(A) Determine eligibility for the aid;

(B) Determine the amount of the aid;

(C) Determine the conditions for the aid; or

(D) Enforce the terms and conditions of the aid.

(ii) As used in paragraph (a)(4)(i) of this section, "financial aid" means a payment of funds provided to an individual (or a payment in kind of tangible or intangible property to the individual) that is conditioned on the individual's attendance at an educational agency or institution.

(20 U.S.C. 1232g(b)(1)(D))

(5)(i) The disclosure is to State and local officials or authorities, if a State statute adopted before November 19, 1974, specifically requires disclosure to those officials and authorities.

(ii) Paragraph (a)(5)(i) of this section does not prevent a State from further limiting the number or type of State or local officials to whom disclosures may be made under that paragraph.

(6)(i) The disclosure is to organizations conducting studies for, or on behalf of, educational agencies or institutions to—

(A) Develop, validate, or administer predictive tests;

(B) Administer student aid programs; or

(C) Improve instruction.

(ii) The agency or institution may disclose information under paragraph (a)(6)(i) of this section only if—

(A) The study is conducted in a manner that does not permit personal identification of parents or students by individuals other than representatives of the organization; and

(B) The information is destroyed when no longer needed for the purposes for which the study was conducted.

(iii) For the purposes of paragraph (a)(6) of this section, the term "organization" includes, but is not limited to, Federal, State, and local agencies, and independent organizations.

(7) The disclosure is to accrediting organizations to carry out their accrediting functions.

(8) The disclosure is to parents of a dependent student, as defined in section 152 of the Internal Revenue Code of 1954.

(9)(i) The disclosure is to comply with a judicial order or lawfully issued subpoena.

(ii) The educational agency or institution may disclose information under paragraph (a)(9)(i) of this section only if the agency or institution makes a reasonable effort to notify the parent or eligible student of the order or subpoena in advance of compliance.

(10) The disclosure is in connection with a health or safety emergency, under the conditions described in § 99.36.

(11) The disclosure is information the educational agency or institution has designated as "directory information", under the conditions described in § 99.37.

(12) The disclosure is to the parent of a student who is not an eligible student or to the student.

(b) This section does not forbid or require an educational agency or institution to disclose personally identifiable information from the education records of a student to any parties under paragraphs (a) (1) through (11) of this section.

(20 U.S.C. 1232g (a)(5)(A), (b)(1) and (b)(2)(B))

§ 99.32 What recordkeeping requirements exist concerning requests and disclosures?

(a)(1) An educational agency or institution shall maintain a list recording each request for access to and each disclosure of personally identifiable information from the education records of each student.

(2) The agency or institution shall maintain the list with the education records of the student as long as the records are maintained.

(3) For each request or disclosure the list must include—

(i) The parties who have requested or received personally identifiable information from the education records; and

(ii) The legitimate interests the parties had in requesting or obtaining the information.

(b) If an educational agency or institution discloses personally identifiable information from an education record with the understanding authorized under § 99.33(b), the record of the disclosure required under this section must include—

(1) The names of the additional parties to which the receiving party may disclose the information on behalf of the educational agency or institution; and

(2) The legitimate interests under § 99.31 which each of the additional parties has in requesting or obtaining the information.

(c) The following parties may inspect the list relating to each student:

(1) The parent or eligible student.

(2) The school official or his or her assistants who are responsible for the custody of the records.

(3) Those parties authorized in § 99.31(a) (1) and (3) for the purpose of

auditing the recordkeeping procedures of the educational agency or institution.

(d) Paragraph (a) of this section does not apply if the request was from, or the disclosure was to—

(1) The parent or eligible student;

(2) A school official under § 99.31(a)(1);

(3) A party with written consent from the parent or eligible student; or

(4) A party seeking directory information.

(20 U.S.C. 1232g(b)(4)(A))

§ 99.33 What limitations apply to the redisclosure of information?

(a)(1) An educational agency or institution may disclose personally identifiable information from an education record only on the condition that the party to whom the information is disclosed will not disclose the information to any other party without the prior written consent of the parent or eligible student.

(2) The officers, employees, and agents of a party that receives information under paragraph (a)(1) of this section may use the information, but only for the purposes for which the disclosure was made.

(b) Paragraph (a) of this section does not prevent an educational agency or institution from disclosing personally identifiable information with the understanding that the party receiving the information may make further disclosures of the information on behalf of the educational agency or institution if—

(1) The disclosures meet the requirements of § 99.31; and

(2) The educational agency or institution has complied with the requirements of § 99.32(b).

(c) Paragraph (a) of this section does not apply to disclosures of directory information under § 99.31(a)11) or to disclosures to a parent or student under § 99.31(a)(12).

(d) Except for disclosures under § 99.31(a) (11) and (12), an educational agency or institution shall inform a party to whom disclosure is made of the requirements of this section

(20 U.S.C. 1232g(b)(4)(B))

§ 99.34 What conditions apply to disclosure of information to other educational agencies or institutions?

(a) An educational agency or institution that discloses an education record under § 99.31(a)(2) shall—

(1) Make a reasonable attempt to notify the parent or eligible student at the last known address of the parent or eligible student, unless—

(i) The disclosure is initiated by the parent or eligible student; or

(ii) The policy of the agency or institution under § 99.6 includes a notice that the agency or institution forwards education records to other agencies or institutions that have requested the records and in which the student seeks or intends to enroll;

(2) Give the parent or eligible student, upon request, a copy of the record that was disclosed; and

(3) Give the parent or eligible student, upon request, an opportunity for a hearing under Subpart C.

(b) An educational agency or institution may disclose an education record of a student to another educational agency or institution if—

(1) The student is enrolled in or receives services from the other agency or institution; and

(2) The disclosure meets the requirements of paragraph (a) of this section.

(20 U.S.C. 1232g(b)(1)(B))

§ 99.35 What conditions apply to disclosure of information for Federal or State program purposes?

(a) The officials listed in § 99.31(a)(3) may have access to education records in connection with an audit or evaluation of Federal or State supported education programs, or for the enforcement of or compliance with Federal legal requirements which relate to those programs.

(b) Information that is collected under paragraph (a) of this section must—

(1) Be protected in a manner that does not permit personal identification of individuals by anyone except the officials referred to in paragraph (a) of this section; and

(2) Be destroyed when no longer needed for the purposes listed in paragraph (a) of this section.

(c) Paragraph (b) of this section does not apply if—

(1) The parent or eligible student has given written consent for the disclosure under § 99.30; or

(2) The collection of personally identifiable information is specifically authorized by Federal law.

(20 U.S.C. 1232g(b)(3))

§ 99.36 What conditions apply to disclosure of information in health and safety emergencies?

(a) An educational agency or institution may disclose personally identifiable information from an education record to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals.

(b) Paragraph (a) of this section shall be strictly construed.

(20 U.S.C. 1232g(b)(1)(I))

§ 99.37 What conditions apply to disclosing directory information?

(a) An educational agency or institution may disclose directory information if it has given public notice to parents of students in attendance and eligible students in attendance at the agency or institution of—

(1) The types of personally identifiable information that the agency or institution has designated as directory information;

(2) A parent's or eligible student's right to refuse to let the agency or institution designate any or all of those types of information about the student as directory information; and

(3) The period of time within which a parent or eligible student has to notify the agency or institution in writing that he or she does not want any or all of those types of information about the student designated as directory information.

(b) An educational agency or institution may disclose directory information about former students without meeting the conditions in paragraph (a) of this section.

(20 U.S.C. 1232g(a)(5) (A) and (B))

Subpart E—What are the Enforcement Procedures?

§ 99.60 What functions has the Secretary delegated to the Office and to the Education Appeal Board?

(a) For the purposes of this subpart, "Office" means the Student and Family Education Rights and Privacy Office, U.S. Department of Education.

(b) The Secretary designates the Office to—

(1) Investigate, process, and review complaints and violations under the Act and this part; and

(2) Provide technical assistance to ensure compliance with the Act and this part.

(c) The Secretary designates the Education Appeal Board to act as the Review Board required under the Act.

(20 U.S.C. 1232g(f) and (g), 1234)

§ 99.61 What responsibility does an educational agency or institution have concerning conflict with State or local laws?

If an educational agency or institution determines that it cannot comply with the Act or this part due to a conflict with State or local law, it shall notify the Office within 45 days, giving the text and citation of the conflicting law.

(20 U.S.C. 1232g(f))

§ 99.62 What information must an educational agency or institution submit to the Office?

The Office may require an educational agency or istitution to submit reports containing information necessary to resolve complaints under the Act and the regulations in this part.

(20 U.S.C. 1232g(f) and (g))

§ 99.63 Where are complaints filed?

A person may file a written complaint with the Office regarding an alleged violation under the Act and this part. The Office's address is: Student and Family Education Rights and Privacy Office, U.S. Department of Education, Washington, DC 20202.

(20 U.S.C. 1232g(g))

§ 99.64 What is the complaint procedure?

(a) A complaint filed under § 99.63 must contain specific allegations of fact giving reasonable cause to believe that a violation of the Act or this part has occurred.

(b) The Office investigates each timely complaint to determine whether the educational agency or institution has failed to comply with the provisions of the Act or this part.

(20 U.S.C. 1232g(f))

§ 99.65 What is the content of the notice of complaint issued by the Office?

(a) If the Office receives a complaint, it notifies the complainant and the educational agency or institution against which the violation has been alleged, in writing, that the complaint has been received.

(b) The notice to the agency or institution under paragraph (a) of this section—

(1) Includes the substance of the alleged violation; and

(2) Informs the agency or institution that the Office will investigate the complaint and that the educational agency or institution may submit a written response to the complaint.

(20 U.S.C. 1232g(g))

§ 99.66 What are the responsibilities of the Office in the enforcement process?

(a) The Office reviews the complaint and response and may permit the parties to submit further written or oral arguments or information.

(b) Following its investigation, the Office provides to the complainant and the educational agency or institution written notice of its findings and the basis for its findings.

(c) If the Office finds that the educational agency or institution has not complied with the Act or this part, the notice under paragraph (b) of this section—

(1) Includes a statement of the specific steps that the agency or institution must take to comply; and

(2) Provides a reasonable period of time, given all of the circumstances of the case, during which the educational agency or institution may comply voluntarily.

(20 U.S.C. 1232g(f))

§ 99.67 How does the Secretary enforce decisions?

(a) If the educational agency or institution does not comply during the period of time set under § 99.66(c), the Secretary may take an action authorized under 34 CFR Part 78, including—

(1) Issuing a notice of intent to terminate funds under 34 CFR 78.21;

(2) Issuing a notice to withhold funds under 34 CFR 78.21, 200.94(b) or 298.45(b), depending upon the applicable program under which the notice is issued; or

(3) Issuing a notice to cease and desist under 34 CFR 78.31, 200.94(c) or 298.45(c), depending upon the program under which the notice is issued.

(b) If, after an investigation under § 99.66, the Secretary finds that an educational agency or institution has complied voluntarily with the Act or this part, the Secretary provides the complainant and the agency or institution written notice of the decision and the basis for the decision.

Note: 34 CFR Part 78 cointains the regulations of the Education Appeal Board.)

(20 U.S.C. 1232(g)

APPENDIX*—DISTRIBUTION TABLE

[Family Educational Rights and Privacy Act]

Old section	New section	Comments
99.1(a)	99.1(a)	
99.1(b)	99.1(b)	
99.1(c)	99.1(c)	
99.1(d)	99.3	"Student".
99.2	99.2	
99.3 the same except as noted		
Educational institution second sentence	99.1(d)	
Education records (b)(4)(iii) medical records proviso.	99.10(f)	
Financial Aid	99.31(a)(4)(ii)	
Panel		Deleted.
Parent—presumption	99.4	
Student (b)	99.5(c)	
Example		Deleted.
	99.4	New.
99.4(a)	99.5(a)	
99.4(b)		Deleted.
99.4(c)	99.5(b)	
99.5	99.6	
99.6(a)	99.7(a) & (b)	
99.6(a)(1)	99.7(a)(1) & (3)	
99.6(a)(2)	99.7(a)(2)	
99.6(b)	99.7(c)	
99.7(a) & (b)		Deleted.
99.7(c)	99.12(c)(2)	
99.7(c)(1)	99.12(c)(2)(i)	
99.7(c)(2)	99.12(c)(2)(ii)	
99.7(c)(3)	99.12(c)(1)(i)	
99.7(d)	99.12(c)(1)(ii)	
99.7(e)		Deleted.
99.7(f)(1)	99.12(c)(3)(i)	
99.7(f)(2)	99.12(c)(3)(ii)	
99.7(f)(3)		Deleted.
99.8(a)	99.11(a)	
99.8(b)	99.11(b)	
99.11(a)	99.10(a) & (b)	
99.11(b)(1)	99.10(c)	
99.11(b)(2)	99.10(d)	
99.11(c)	99.4	
99.12(a)(1)	99.12(b)(1)	
99.12(a)(2)	99.12(b)(2)	
99.12(a)(2)(i)		Deleted.
99.12(a)(2)(ii)	99.12(b)(2)	
99.12(a)(3)(1)(i)(ii) & (iii)	99.12(b)(3)(i) & (ii)	
99.12(b)	99.12(a)	

APPENDIX*—DISTRIBUTION TABLE—Continued

[Family Educational Rights and Privacy Act]

Old section	New section	Comments
99.7(c)(3)	99.12(c)(1)(i)	
99.7(d)	99.12(c)(1)(ii)	
99.7(e)		Deleted.
99.7(f)(1)	99.12(c)(3)(i)	
99.7(f)(2)	99.12(c)(3)(ii)	
99.7(f)(3)		Deleted.
99.8(a)	99.11(a)	
99.8(b)	99.11(b)	
99.11(a)	99.10(a) & (b)	
99.11(b)(1)	99.10(c)	
99.11(b)(2)	99.10(d)	
99.11(c)	99.4	
99.12(a)(1)	99.12(b)(1)	
99.12(a)(2)	99.12(b)(2)	
99.12(a)(2)(i)		Deleted.
99.12(a)(2)(ii)	99.12(b)(2)	
99.12(a)(3)(1)(i)(ii) & (iii)	99.12(b)(3)(i) & (ii)	
99.12(b)	99.12(a)	
99.13(a)	99.10(e)	
99.13(b)	99.21(c)(1)	
99.13(c)	99.32(a)(2)	
99.20	99.20	
99.21(a)	99.21(a)	
99.21(b)	99.21(b)(1)	
99.21(c)	99.21(b)(2)	
99.21(d)(1) & (2)	99.21(c)(1) & (2)	
99.22(a)	99.22(a) & (b)	
99.22(b)	99.22(c)	
99.22(c)	99.22(d)	
99.22(d)	99.22(e)	
99.22(e)	99.22(f)	
99.30(a)(1)	99.30(a)	
99.30(a)(1) (Directory information)	99.31(a)(11)	
99.30(a)(2)	99.31(a)(12)	
99.30(b)	99.4	
99.30(c)	99.30(a)	
99.30(c)(1)(2) & (3)	99.30(b)(1)(2) & (3)	
99.30(d)	99.30(c)	
99.31(a)(1-10) & (b)	99.31(a)(1-10) & (b)	
99.32(a)	99.32(a)(1)	
99.32(a)(1) & (2)	99.32(a)(3)	
99.32(b)	99.32(d)	
99.32(c)	99.32(c)	
	99.32(b)	New.
99.33(a)	99.33(a)	
99.33(b)	99.33(b)	
99.33(c)	99.33(d)	
	99.33(c)	New.
99.34(a)	99.34(a)	
99.34(b)	99.34(b) & (c)	
99.35(a)	99.35(a)	
99.35(b)	99.35(b)	
99.36(b)	Deleted	
99.36(c)	99.36(b)	
99.37(a)	99.37(a)	
99.37(b)	99.37(b)	
99.37(c)(1)(2) & (3)	99.37(a)(1)(2) & (3)	
99.60(a)	99.60(b) & (c)	
99.60(b)	99.63	
	99.60(a)	New.
99.61	99.61	
99.62	99.62	
99.63(a)	99.63	
99.63(b)(1)	99.65(a)	
99.63(b)(2)	99.65(b)	
99.63(c)(1)	99.64(b) & 99.66(a)	
99.63(c)(2)	99.66(b)	
99.63(c)(3)	99.66(c)	
99.63(d)	99.67(a)	

APPENDIX*—DISTRIBUTION TABLE—Continued

[Family Educational Rights and Privacy Act]

Old section	New section	Comments
99.64	99.67	
99.65	99.67	
99.66	99.67	
99.67	99.67	

*This Appendix is supplied to the reader as an aid to compare the current regulations with the proposed regulations. It will not be included in the final rulemaking document for these regulations or codified in the Code of Federal Regulations.

[FR Doc. 87-13220 Filed 6-9-87; 8:45 am]
BILLING CODE 4000-01-M

Federal Register

Wednesday
June 10, 1987

Part VII

Department of Education

34 CFR Part 607

Strengthening Institutions Program; Proposed Rule

DEPARTMENT OF EDUCATION

34 CFR Part 607

Strengthening Institutions Program

AGENCY: Department of Education.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Secretary proposes regulations to govern the new Strengthening Institutions Program authorized by Part A of Title III of the Higher Education Act of 1965 (HEA). These regulations are needed to implement changes made to Title III of the HEA by the Higher Amendments of 1986, Public Law 99-498.

DATES: Comments must be received on or before July 10, 1987.

ADDRESSES: All comments concerning these proposed regulations should be addressed to: Dr. Caroline J. Gillin, Director, Institutional Aid Programs, U.S. Department of Education, L'Enfant Plaza, Post Office Box 23868, Washington, DC 20026.

A copy of any comments that concern information collection requirements should also be sent to the Office of Management and Budget at the address listed in the Paperwork Reduction Act section of this preamble.

FOR FURTHER INFORMATION CONTACT: Dr. Caroline J. Gillin, Telephone: (202) 732-3308.

SUPPLEMENTARY INFORMATION: The Institutional Aid Programs, authorized by Title III of the HEA provide Federal financial assistance to institutions of higher education to assist them in equalizing educational opportunity. There are four programs collectively known as the Institutional Aid Programs. The Strengthening Institutions Program is one of the Institutional Aid Programs.

The Strengthening Institutions Program, authorized under Part A of Title III, authorizes grants to eligible institutions of higher education for projects to improve their academic quality, institutional management and fiscal stability. The objective of this program is to help eligible institutions increase their self-sufficiency and strengthen their capacity to make a contribution to the higher education resources of the Nation.

Two-year and four-year, public and nonprofit private institutions of higher education—including branch campuses under certain conditions—may be eligible to receive grants under the Strengthening Institutions Program.

Eligibility

To be eligible to compete for a new grant under the Strengthening Institutions program in any given year, an institution must be designated by the Secretary as an eligible institution. The proposed eligibility requirements and method for designating institutions as eligible are found in §607.2-§607.5.

In order to qualify as an eligible institution under the Strengthening Institutions Program, an institution must first qualify as an eligible "institution of higher education" as that term is defined under section 1201(a) of the HEA. An institution that qualifies as an eligible institution of higher education under section 1201(a) of the HEA must then satisfy the eligibility requirements set forth in section 312 of the HEA.

To qualify as an eligible institution for the Strengthening Institutions Program under section 312, unless specific statutory exceptions apply, an institution of higher education must provide an educational program for which it awards a bachelor's degree or it must qualify as a junior or community college and it must satisfy either of these requirements for at least five academic years. It must be accredited or preaccredited, *i.e.*, receive candidacy status from an accrediting association recognized by the Secretary to accord that status, and it must have also satisfied this requirement for at least five academic years. In addition, an eligible institution must serve financially needy students and have comparatively low educational and general expenditures per undergraduate full-time equivalent student.

As a way of determining whether an institution serves financially needy students, section 312 establishes two alternative measures. Under one measure, at least half of an institution's enrollment must consists of students who receive in the base year financial aid under one or more of the following four programs: the Pell Grant, Supplemental Education Opportunity Grant, College Work-Study or Perkins Loan Programs. (The Perkins Loan Program was previously called the National Direct Student Loan Program.)

Under the other measure, a substantial percentage of the institution's enrollment of at least half-time, undergraduate, degree students must have received grants under the Pell Grant Program in the base year when compared to the percentage of at least half-time, undergraduate, degree students receiving Pell Grants at similar type institutions in that year. For the purpose of this comparison, as well as other comparisions under these regulations, the Secretary considers that there are four types of institutions: Public junior or community colleges (two-year public institutions), private nonprofit junior or community colleges (two-year private institutions), public institutions that provide an educational program for which a bachelor's degree is awarded (four-year public institutions), and private nonprofit institutions that provide an educational program for which a bachelor's degree is awarded (four-year private institutions).

When determining whether an institution has a substantial percentage of Pell Grant recipients, the Secretary will compare the institution's percentage of recipients against the median percentage of Pell Grant recipients for that type of institution. In order for the institution to qualify as having a substantial percentage of Pell Grant recipients, the institution's percentage of recipients must exceed the median percentage of recipients for that type of institution. The median percentage of Pell Grant recipients for a type of institution is the percentage at which half of the reported percentages for institutions of that type are above and half of the reported percentages for institutions of that type are below that percentage.

Section 312 of the HEA provides that an institution of higher education that serves a minimum percentage of certain types of ethnic or minority students may qualify as an eligible institution under the Strengthening Institutions Program without meeting all the eligibility requirements contained in section 312, such as being accredited or preaccredited, offering a bachelor's degree program or being a junior college, or satisfying these requirements for five academic years. However, the institution must still qualify as an institution of higher education under section 1201(a) of the Higher Education Act in order to be considered an eligible institution under the Strengthening Institution Program.

To qualify as an eligible institution under the educational and general expenditure requirement, the institution's average educational and general (E&G) expenditure per full-time equivalent (FTE) undergraduate student in the base year must be less than the average E&G expenditure per FTE undergraduate student in that year at similar type institutions.

The base year is defined in these regulations as the second best year preceding the fiscal year for which an institution seeks a grant under this part. For fiscal year 1987, the base year is the 1984-85 school year.

For each type of institution the Secretary will publish annually in the Federal Register thresholds for meeting the Pell Grant median percentage criterion and the E&G expenditures criterion. An institution that receives a grant covering a period of more than one year must submit to the Secretary each year an assurance that it continues to meet the basic qualifications for participation in the Strenthening Institutions Program.

Kinds of Grants

The Secretary awards planning grants and two types of development grants. A planning grant may be awarded for a period of not more than one year. Under a planning grant, a grantee formulates a comprehensive development plan described in § 607.8 and an application for a development grant. An institution that receives a planning grant may not subsequently receive another planning grant but may subsequently receive a development grant for a period of three, four or five years.

The Secretary may award two types of development grants, individual development grants and cooperative arrangement development grants. Under either type of development grant, a grantee carries out activities that implement its comprehensive development plan. Either type of development grant may be awarded for a period of three, four or five years.

An institution that receives a development grant of three years may subsequently receive another development grant of three, four or five years. An institution that receives a development grant of four years may not subsequently receive another development grant for a period of eight years from the date it initially received the four year grant. An institution that receives a development grant of five years may not subsequently receive another development grant for a period of ten years from the date it initially received the five year grant.

The Secretary funds cooperative arrangement development grants if each participating eligible institution will better meet the goals and objectives of its comprehensive development plan at a lower cost under the cooperative arrangement grant than under an individually funded grant.

Comprehensive Development Plan (CDP)

Similar to what has been done in the past, an applicant is required to submit a comprehensive development plan (formerly known as the "long-range plan") as part of its application. The plan is a blueprint of planned action for the entire applicant institution while the rest of the application describes that part of the blueprint that will be carried out with Strengthening Institutions Program funds. The two parts, of course, must fit together logically. If, for example, the plan describes eight major institutional problems, the rest of the application should logically propose activities that remedy those institutional problems.

The review of the comprehensive development plan, however, will be different from the review done in the past. In the past, the Secretary only determined whether the plan satisfied all the elements required for such a plan. In these proposed regulations, the Secretary will review the plan and award up to 25 points for the quality of the plan. The Secretary believes this method of review will produce a higher quality comprehensive development plan.

Allowable Costs and Audit Requirements

Under the Strengthening Institutions Program, a grantee may use grant funds only to carry out developmental activities. In addition, a grantee may only use grant funds to supplement and in no case supplant funds that would otherwise be made available by the institution for grant activities.

Grantees under this program are subject to the cost principles contained in Part II of Appendix D to 34 CFR Part 74. Grantees should bear in mind that the cost principles that govern the charging of employee salaries against a grant are contained in section J.2 of Part II of Appendix D to 34 CFR Part 74. That section incorporates the provisions of sections J.7.b. and d. of Part I of Appendix D to 34 CFR Part 74.

Grantees must provide for the conduct of a compliance and financial audit of the grant in accordance with 34 CFR 74.162(h) by a qualified, independent organization or person in accordance with standards established by the Comptroller General of the United States for the audit of governmental organizations, programs, and functions. The audits must be conducted at least once every two years, covering the period since the previous audit, and a grantee must submit the audit to the Secretary. However, if a grantee is audited under Chapter 75 of Title 31 of the United States Code, the Secretary considers that audit to satisfy the audit requirements of these programs.

Executive Order 12291

These proposed regulations have been reviewed in accordance with Executive Order 12291. They are not classified as major because they do not meet the criteria for major regulations established in the order.

Regulatory Flexibility Act Certification

The Secretary certifies that these proposed regulations would not have a significant economic impact on a substantial number of small entities. While some small institutions of higher education would be affected by these regulations, they would not be subject to excessive regulatory burdens or unnecessary Federal supervision. The regulations would impose minimal requirements to ensure the proper expenditure of project funds.

Paperwork Reduction Act of 1980

Sections 607.11, 607.12, 607.21 and 607.22 contain information collection requirements. As required by the Paperwork Reduction Act of 1980, the Department of Education will submit a copy of these proposed regulations to the Office of Management and Budget (OMB) for its review. Organizations and individuals desiring to submit comments on the information collection requirements should direct them to the Office of Information and Regulatory Affairs, OMB, Room 3002, New Executive Office Building, Washington, DC 20503; Attention: Joseph F. Lackey, Jr.

Invitation to Comment

Interested persons are invited to submit comments and recommendations regarding these proposed regulations.

All comments submitted in response to these proposed regulations will be available for public inspection, during and after the comment period, in Room 3045, Regional Office Building #3, 7th & D Streets, SW., Washington, DC, between the hours of 8:30 a.m. and 4:00 p.m., Monday through Friday of each week, except Federal holidays.

To assist the Department in complying with the specific requirements of Executive Order 12291 and the Paperwork Reduction Act of 1980 and their overall requirement of reducing regulatory burden, the Secretary invites comments on whether there may be further opportunities to reduce any regulatory burdens found in these proposed regulations.

Assessment of Educational Impact

The Secretary particularly requests comments on whether the regulations in this document would require transmission of information that is being gathered by or is available from any other agency or authority of the United States.

List of Subjects in 34 CFR Part 607

Colleges and universities, Education, Reporting and recordkeeping requirements.

(Catalog of Federal Domestic Assistance Number 84.031—Strengthening Institutions Program)

Dated: May 18, 1987.

William J. Bennett,

Secretary of Education.

The Secretary proposes to amend Title 34 of the Code of Federal Regulations by adding a new Part 607 to read as follows:

PART 607—STRENGTHENING INSTITUTIONS PROGRAMS

Subpart A—General

Sec.

Subpart B—How Does an Institution Apply for a Grant?

Subpart C—How Does the Secretary Make an Award?

Subpart D—What Conditions Must a Grantee Meet?

Subpart E—What Compliance Procedures Does the Secretary Use?

Authority: 20 U.S.C. 1057–1059, 1066–1069f, unless otherwise noted.

Subpart A—General

§607.1 What is the Strengthening Institutions Program?

The purpose of the Strengthening Institutions Program is to provide grants to eligible institutions of higher education to enable them to improve their academic quality, institutional management, and fiscal stability in order to increase their self-sufficiency, and strengthen their capacity to make a substantial contribution to the higher education resources of the Nation.

(Authority: 20 U.S.C. 1057)

§ 607.2 What institutions are eligible to receive a grant under the Strengthening Institutions Program?

(a) Except as provided in paragraphs (b), (c) and (d) of this section, an institution of higher education is eligible to receive a grant under the Strengthening Institutions Program if—

(1) It has an enrollment of needy students as described in § 607.3(a), unless the Secretary waives this requirement under § 607.3(b);

(2) It has low average educational and general expenditures per full-time equivalent undergraduate student as described in § 607.4(a), unless the Secretary waives this requirement under § 607.4(c);

(3) It is legally authorized by the State in which it is located to be a junior college or to provide an educational program for which it awards a bachelor's degree;

(4) It is accredited or preaccredited by a nationally recognized accrediting agency or association that the Secretary has determined to be a reliable authority as to the quality of education or training offered; and

(5) It has satisfied the requirements contained in paragraphs (a)(3) and (a)(4) of this section for the five academic years preceding the academic year for which it initially seeks a grant under this part.

(b) An institution of higher education is eligible to receive a grant under the Strengthening Institutions Program even if it does not satisfy the requirements of paragraphs (a)(3), (a)(4) and (a)(5) of this section if its student enrollment consists of at least—

(1) Twenty percent Mexican American, Puerto Rican, Cuban, or other Hispanic students, or any combination thereof; or

(2) Five percent Native Hawaiian, Asian American, American Samoan, Micronesian, Guamian (Chamorro), or Northern Marianian or any combination thereof.

(c) An institution of higher education is eligible to receive a grant under the Strengthening Institutions Program even if it does not satisfy the requirements of paragraph (a)(5) of this section if its student enrollment consists of at least 60 percent American Indian, or in the case of Alaska natives, an enrollment of at least 5 percent Alaska natives.

(d) A branch campus of an institution of higher education is eligible to receive a grant under the Strengthening Institutions Program even if, by itself, it does not satisfy the requirements of paragraphs (a)(3), (a)(4) and (a)(5) of this section, although the institution of which the branch is a part must meet the requirements of paragraphs (a)(1)–(a)(5) of this section.

(e) For the purpose of paragraphs (b) and (c) of this section, an institution's enrollment consists of a head count of its entire student body.

(Authority: 20 U.S.C. 1058)

§ 607.3 What is an enrollment of needy students?

(a) Except as provided in paragraph (b) of this secton, for the purpose of § 607.2(a)(1), an applicant institution has an enrollment of needy students if in the base year—

(1) At least 50 percent of its degree students received student financial assistance under one or more of the following programs: Pell Grant, Supplemental Educational Opportunity Grant, College Work-Study, and Perkins Loan; or

(2)(i) For a public junior or community college, the percentage of its degree students who received Pell Grants exceeded the median percentage of degree students enrolled in all public junior or community colleges who received Pell Grants;

(ii) For a private nonprofit junior or community college, the percentage of its degree students who received Pell Grants exceeded the median percentage of degree students enrolled in all private nonprofit junior or community colleges who received Pell Grants;

(iii) For a public institution providing an educational program for which it awards a bachelor's degree, the percentage of its undergraduate degree students who received Pell Grants exceeded the median percentage of all undergraduate degree students enrolled in all those public institutions who received Pell Grants; or

(iv) For a private nonprofit institution providing an educational program for which it awards a bachelor's degree, the percentage of its undergraduate degree students who received Pell Grants exceeded the median percentage of undergraduate degree students enrolled in all those private nonprofit institutions who received Pell Grants.

(b) The Secretary may waive the requirement contained in paragraph (a) of this section if the institution demonstrates that—

(1) The State provides more than 30 percent of the institution's budget and the institution charges not more than $99.00 for tuition and fees;

(2) At least 90 percent of the students served by the institution in the base year were students from low and middle income families;

(3) The institution substantially increases the higher education opportunities for low-income students who are also educationally disadvantaged, underrepresented in postsecondary education, or minority students;

(4) The institution substantially increases the higher education opportunities for individuals who reside in an area that is not included in a "metropolitan statistical area" as defined by the Office of Management and Budget and who are unserved by other postsecondary institutions;

(5) The institution is located on or within 50 miles of an Indian reservation or a substantial population of Indians and the institution will, if granted the waiver, substantially increase higher education opportunities for American Indians; or

(6) The institution will, if granted the waiver, substantially increase the higher education opportunities for Black Americans, Hispanic Americans, Native Americans, Asian Americans or Pacific Islanders, including Native Hawaiians.

(c) For the purpose of paragraph (b) of this section—

(1) The Secretary considers—

(i) "Low-income" to be an amount which does not exceed 150 percent of the amount equal to the poverty level as established by the United States Bureau of the Census; and

(ii) "Middle-income"' to be an amount which is higher than low-income but does not exceed the 60th percentile of family income as reported by the Census Bureau.

(2) Each year, the Secretary notifies prospective applicants through a notice in the **Federal Register** of the low-income and middle-income figures.

Authority: (20 U.S.C. 1058 and 1067)

§ 607.4 What are low educational and general expenditures?

(a)(1) Except as provided in paragraph (b) of this section, for the purpose of § 607.2 (a)(2), an applicant institution's average educational and general expenditures per full-time equivalent undergraduate student in the base year must be less than the average educational and general expenditures per full-time equivalent undergraduate student of the type of institution that offers similar instruction in that year.

(2) For the purpose of paragraph (a)(1) of this section, the Secretary categorizes institutions as offering similar instruction as follows:

(i) Public junior or community colleges,

(ii) Private nonprofit junior or community colleges,

(iii) Public institutions that offer an educational program for which it offers a bachelor's degree,

(iv) Private nonprofit institutions that offer an educational program for which it offers a bachelor's degree.

(b) Each year, the Secretary notifies prospective applicants through a notice in the **Federal Register** of the average educational and general expenditures per full-time equivalent undergraduate student of the four types of institutions described in paragraph (a)(2) of this section.

(c) The Secretary may waive the requirement contained in paragraph (a) of this section, if the Secretary determines, based upon persuasive evidence provided by the institution, that—

(1) The institution's failure to satisfy the criteria in paragraph (a) of this section was due to factors which, if used in determining compliance with those criteria, distorted that determination; and

(2) The institution's designation as an eligible institution under this part is otherwise consistent with the purposes of this part.

(d) For the purpose of paragraph (c)(1) of this section, the Secretary considers that the following factors may distort an institution's educational and general expenditures per full-time equivalent undergraduate student—

(1) Low student enrollment;

(2) Location of the institution in an unusually high cost-of-living area;

(3) High energy costs;

(4) An increase in State funding that was part of a desegregation plan for higher education; and

(5) Operation of high cost professional schools such as medical or dental schools.

(Authority: 20 U.S.C. 1058 and 1067)

§ 607.5 How does an institution apply to be designated an eligible institution?

An institution shall apply to the Secretary to be designated an eligible institution under the Strengthening Institutions Program by submitting an application to the Secretary in the form, manner and time established by the Secretary. The application must contain—

(a) The information necessary for the Secretary to determine whether the institution satisfies the requirements of § 607.2, § 607.3(a) and § 607.4(a);

(b) Any waiver request under § 607.3(b) and § 607.4(c); and

(c) Information or explanations justifying any requested waiver.

(Authority: 20 U.S.C. 1058 and 1067)

§ 607.6 What regulations apply?

The following regulations apply to the Strengthening Institutions Program:

(a) The Education Department General Administrative Regulations (EDGAR) in 34 CFR Part 74 (Administration of Grants); Part 75 (Direct Grant Programs), except 34 CFR 75.128(a)(2) and 75.129(a) in the case of applications under cooperative arrangements; Part 77 (Definitions That Apply to Department Regulations; and Part 78 (Education Appeal Board).

(b) The regulation in this part.

(Authority: 20 U.S.C. 1221e-3(a)(1), 1057, 1060, 1064)

§ 607.7 What definitions apply?

(a) *Definitions in EDGAR.* The following terms that apply to the Institutional Aid Programs are defined in 34 CFR 77.1:

EDGAR
Fiscal year
Grant
Grantee
Grant period
Nonprofit
Private
Project
Project period
Public
Secretary
State

(b) The following definitions also apply to this part:

"Accredited" means the status of public recognition which a nationally recognized accrediting agency or association grants to an institution which meets certain established qualifications and educational standards.

"Activity" means an action or actions which are incorporated into an implementation plan designed to meet

an objective. An activity is a subpart of a project.

"Base year" means the second fiscal year preceding the fiscal year for which an institution seeks a grant under this part.

"Branch campus" means a unit of a college or university that is geographically apart from the main campus of the college or university and independent of that main campus. The Secretary considers a unit of a college or university to be independent of the main campus if the unit—

(1) Is permanent in nature;

(2) Offers courses for credit and programs leading to an associate or bachelor's degree; and

(3) Is autonomous to the extent that it has—

(i) Its own faculty and administrative or supervisory organization; and

(ii) Its own budgetary and hiring authority.

"College Work-Study Program" means the part-time employment program authorized under Title IV–C of the HEA.

"Cooperative arrangement" means an arrangement to carry out allowable grant activities between an institution eligible to receive a grant under this part and another eligible or ineligible institution of higher education, under which the resources of the cooperating institutions are combined and shared to better achieve the purposes of this part and avoid costly duplication of effort.

"Degree student" means a student who enrolls at an institution for the purpose of obtaining the degree or certificate offered by that institution.

"Developmental program and services" means new or improved programs and services, beyond those regularly budgeted, specifically designed to improve the self sufficiency of the school.

"Educational and general expenditures" means the total amount expended by an institution of higher education for instruction, research, public service, academic support (including library expenditures), student services, institutional support, scholarships and fellowships, operation and maintenance expenditures for the physical plant, and any mandatory transfers which the institution is required to pay by law.

"Full-time equivalent students" means the sum of the number of students enrolled full-time at an institution, plus the full-time equivalent of the number of students enrolled part time (determined on the basis of the quotient of the sum of the credit hours of all part-time students divided by 12) at such institution.

"HEA" means the Higher Education Act of 1965, as amended.

"Institution of higher education" means an educational institution defined in section 1201(a) of the HEA.

"Junior or community college" means an institution of higher education—

(1) That admits as regular students persons who are beyond the age of compulsory school attendance in the State in which the institution is located and who have the ability to benefit from the training offered by the institution;

(2) That does not provide an educational program for which it awards a bachelor's degree (or an equivalent degree); and

(3) That—

(i) Provides an educational program of not less than 2 years that is acceptable for full credit toward such a degree, or

(ii) Offers a 2-year program in engineering, mathematics, or the physical or biological sciences, designed to prepare a student to work as a technician or at the semiprofessional level in engineering, scientific, or other technological fields requiring the understanding and application of basic engineering, scientific, or mathematical principles of knowledge.

"Nationally recognized accrediting agency or association" means an accrediting agency or association that the Secretary has recognized to accredit or preaccredit a particular category of institution in accordance with the provisions contained in 34 CFR Part 603. The Secretary periodically publishes a list of those nationally recognized accrediting agencies and associations in the **Federal Register.**

"Operational programs and services" means the regular, ongoing budgeted programs and services at an institution.

"Pell Grant Program" means the grant program authorized by Title IV–A–1 of the HEA.

"Perkins Loan Program", formerly called the National Direct Student Loan Program, means the loan program authorized by Title IV–E of the HEA.

"Preaccredited" means a status that a nationally recognized accrediting agency or association, recognized by the Secretary to grant that status, has accorded an unaccredited institution that is progressing toward accreditation within a reasonable period of time.

"Project" means all the funded activities under a grant.

"Self-sufficiency" means the point at which an institution is able to survive without continued funding under the Strengthening Institutions Program.

"Special Needs Program" means the program authorized by Part B of Title III of the HEA before Part B was amended by the Higher Education Amendments of 1986.

"Strengthening Program" means the program authorized by Part A of Title III of the HEA before Part A was amended by the Higher Education Amendments of 1986.

"Supplemental Education Opportunity Grant" means the grant program authorized by Title IV A–2 of the HEA.

(Authority: 20 U.S.C. 1051, 1057–1059 and 1066–1069f)

§ 607.8 What is a comprehensive development plan and what must it contain?

(a) A comprehensive development plan describes an institution's strategy for achieving growth and self-sufficiency by strengthening its—

(1) Academic quality;

(2) Institutional management; and

(3) Fiscal stability.

(b) The comprehensive development plan must include the following—

(1) The institutional mission statement, i.e. a broad statement of purpose, which identifies certain of its distinguishing characteristics, including the characteristics of the students it proposes to serve and the programs of study it proposes to offer.

(2) Assumptions concerning the institutional environment, enrollment trends and economic factors which affect the institution;

(3) Major problems or deficiencies that inhibit the institution from becoming self-sufficient;

(4) Long-range and short-range goals that will chart the growth and development of the institution and address the problems identified under paragraph (b)(3) of this section;

(5) Measurable objectives related to reaching each goal;

(6) Priorities for implementing improvements or corrective actions and for allocating resources to achieve these goals and objectives;

(7) Timeframes for achieving the goals and objectives described in paragraphs (b)(5) and (b)(6) of this section;

(8) Major resource requirements necessary to achieve the goals and objectives of the plan, including personnel, financial, equipment and facilities; and

(9) Strategies and resources for objectively evaluating the institution's progress towards, and success, in achieving its goals and objectives.

(Authority: 20 U.S.C. 1066)

§ 607.9 What are the type, duration and limitations in the awarding of grants under this part?

(a)(1) Under this part, the Secretary may award planning grants and two types of development grants, individual

development grants and cooperative arrangement development grants.

(2) Planning grants may be awarded for a period not to exceed one year.

(3) Either type of development grant may be awarded for a period of one through five years.

(b)(1) An institution that receives a planning grant may not subsequently receive another planning grant but may subsequently receive a development grant.

(2) An institution that receives a development grant of up to three years may subsequently receive another development grant.

(3) An institution that receives a development grant of four years may not subsequently receive another development grant for a period of eight years from the date it received the four year grant.

(4) An institution that receives a development grant of five years may not subsequently receive another development grant for a period of ten years from the date it received the five year grant.

(Authority: 20 U.S.C. 1059)

§ 607.10 What activities may and may not be carried out under a grant?

(a) *Planning grants.* Under a planning grant, a grantee shall formulate—

(1) A comprehensive development plan described in § 607.8; and

(2) An application for a development grant.

(b) *Development grants—allowable activities.* Under a development grant, exept as provided in paragraph (c) of this section, a grantee shall carry out activities that implement its comprehensive development plan and hold promise for strengthening the institution. Activities that may be carried out include, but are not limited to—

(1) Faculty development;

(2) Funds and administrative management;

(3) Development and improvement of academic programs;

(4) Acquisition of equipment for use in strengthening management and academic programs;

(5) Joint use of facilities such as libraries and laboratories; and

(6) Student services.

(c) *Development grants—unallowable activities.* A grantee may not carry out the following activities under a development grant:

(1) Activities that are not included in the grantee's approved application;

(2) Activities that are inconsistent with any State plan of higher education that is applicable to the institution;

(3) Activities that are inconsistent with a State plan for desegregation of higher education that is applicable to the institution;

(4) Activities or services that relate to sectarian instruction or religious worship:

(5) Activities provided by a school or department of divinity. For the purpose of this provision, a "school or department of divinity" means an institution, or a department of an institution, whose program is specifically for the education of students to prepare them to become ministers of religion or to enter upon some other religious vocation, or to prepare them to teach theological subjects;

(6) Development or improvement of nondegree or noncredit courses other than basic skills development courses;

(7) Development or improvement of community-based or community services programs, unless the program provides academic-related experiences or academic credit toward a degree for degree students;

(8) Replacement or upgrading of standard office equipment such as furniture, file cabinets, bookcases, typewriters or word processors;

(9) Services to high school students;

(10) Instruction in the institution's standard courses as indicated in the institution's catalog;

(11) Student activities such as entertainment, cultural, or social enrichment programs, publications or social clubs or associations; and

(12) Activities which are operational in nature rather than developmental.

(Authority: 20 U.S.C. 1057 and 1069c)

Subpart B—How Does an Institution Apply for a Grant?

§ 607.11 What must be included in individual development grant applications?

In addition to the information needed by the Secretary to determine whether the institution should be awarded a grant under the funding criteria contained in Subpart C, an application for a development grant must include—

(a) The institution's comprehensive development plan;

(b) A description of the relationship of each activity for which grant funds are requested to the relevant goals and objectives of its plan; and

(c) A description of any activities that were funded under previous Strengthening or Special Needs Program grants and the institution's justification for not completing the activities under the previous grant, if grant funds are requested to continue or complete the activities;

(d) The provisions required by section 351 of the HEA which are not specified in other sections of this part. These provisions require that an institution applying for more than one activity shall—

(1) Identify those activities that would be a sound investment of Federal funds if funded separately;

(2) Identify those activities that would be a sound investment of Federal funds only if funded with the other activities; and

(3) Rank the activities in preferred funding order.

(Authority: 20 U.S.C. 1066)

§ 607.12 What must be included in cooperative arrangement grant applications?

(a)(1) Institutions applying for a cooperative arrangement grant shall submit only one application for that grant regardless of the number of institutions participating in the cooperative arrangement.

(2) The application must include the names of each participating institution, the role of each institution, and the rationale for each eligible participating institution's decision to request grant funds as part of a cooperative arrangement rather than as an individual grantee.

(b) If the application is for a development grant, the application must contain—

(1) Each participating institution's comprehensive development plan;

(2) The information required under § 607.11; and

(3) An explanation from each eligible participating institution of why participation in a cooperative arrangement grant rather than performance under an individual grant will better enable it to meet the goals and objectives of its comprehensive development plan at a lower cost.

(Authority: 20 U.S.C. 1066 and 1069)

§607.13 How many applications for a development grant may an institution submit?

An institution of higher education may—

(a) Submit only one application for an individual development grant, and;

(b) Be part of only one cooperative arrangement application.

(Authority: 20 U.S.C. 1057–1059, 1066–1069f)

Subpart C—How Does the Secretary Make an Award?

§ 607.20 How does the Secretary evaluate an application?

(a) The Secretary evaluates an application on the basis of the selection criteria in—

(1) Section 607.21 for a planning grant;

(2) Section 607.22 for a development grant, and;

(3) Section 607.23 with regard to special funding considerations.

(b)(1) The Secretary awards up to 100 points for the criteria in § 607.21, up to 100 points for the criteria in §607.22, up two additional points for the criteria in § 607.23(a) and up to three additional points for the criteria in § 607.23(b).

(2) The maximum possible score for each complete criterion is in parentheses following the title of that criterion.

(c)(1) The Secretary does not fund an application for a planning grant that scores less than 50 points under § 607.21; and

(2) The Secretary does not fund an application for a development grant that—

(i) Scores less than 50 points under § 607.22;

(ii) Is submitted without a comprehensive development plan;

(iii) Is submitted with a comprehensive development plan that does not satisfy all the elements required of such a plan under § 607.8; or

(iv) In the case of an application for a cooperative arrangement grant, does not demonstrate that funding the cooperative arrangement grant will enable each eligible participant to meet the goals and objectives of its comprehensive development plan better and at a lower cost than if each eligible participant were funded individually.

(Authority: 20 U.S.C. 1057–1059, 1066–1069f)

§ 607.21 What are the selection criteria for planning grants?

The Secretary uses the following criteria to evaluate an application to determine whether the applicant will produce a good comprehensive development plan and a fundable Strengthening Institutions Program application:

(a) *Design of the planning process.* (Total: 60 points) The Secretary reviews each application to determine the quality of the planning process that the applicant will use to develop a comprehensive development plan and an application for a development grant based on the extent to which—

(1) The planning process is clearly and comprehensively described and based on sound planning practice (15 points);

(2) The president or chief executive officer, administrators and other institutional personnel, students, and governing board members systematically and consistently will be involved in the planning process (15 points);

(3) The applicant will use its own resources to help implement the project (10 points); and

(4) The planning process is likely to achieve its intended results (20 points).

(b) *Key personnel.* (Total: 20 points) The Secretary reviews each application to determine the quality of key personnel to be involved in the project based on the extent to which—

(1) The past experience and training of key personnel such as the project coordinator and persons who have key roles in the planning process are suitable to the tasks to be performed (10 points); and

(2) The time commitments of key personnel are adequate (10 points).

(c) *Project Management.* (Total: 15 points) The Secretary reviews each application to determine the quality of the plan to manage the project effectively based on the extent to which—

(1) The procedures for managing the project are likely to ensure effective and efficient project implementation (10 points); and

(2) The project coordinator has sufficient authority, including access to the president or chief executive officer, to conduct the project effectively (5 points).

(d) *Budget.* (Total: 5 points) The Secretary reviews each application to determine the extent to which the proposed project costs are necessary and reasonable.

(Authority: 20 U.S.C. 1057–1059, 1066–1069f)

§ 607.22 What are the selection criteria for development grants?

The Secretary uses the following criteria to evaluate applications for development grants:

(a) *Quality of the applicant's comprehensive development plan (CDP)* (Total: 25 points) The extent to which the implementation of the applicant's comprehensive development plan will strengthen the applicant's academic quality, institutional management, fiscal stability and otherwise provide for institutional growth and self-sufficiency.

(b) *Quality of project objectives.* (Total: 10 points) The extent to which the objectives for each activity are—

(1) Realistic and defined in terms of measurable results (5 points); and

(2) Directly related to the problems to be solved and to the goals of the CDP (5 points).

(c) *Quality of implementation strategy.* (Total: 30 points) The extent to which an applicant's—

(1) Implementation strategy for each activity is comprehensive, based on a sound rationale, and likely to be effective (25 points); and

(2) Timetable for each activity is realistic (5 points).

(d) *Quality of key personnel.* (Total: 10 points) The extent to which—

(1) The past experience and training of key professional personnel are directly related to the stated activity purposes and objectives (7 points); and

(2) The time commitment of key personnel is realistic (3 points).

(e) *Quality of project management plan.* (Total: 10 points) The extent to which—

(1) Procedures for managing the project are likely to ensure efficient and effective project implementation (5 points); and

(2) The project coordinator and activity directors have sufficient authority to conduct the project effectively including access to the president or chief executive officer. (5 points).

(f) *Quality of evaluation plan.* (Total: 5 points) The extent to which the evaluation plan—

(1) Includes the information in § 607.8(b)(9); and

(2) Is likely to produce a valid assessment of the implementation strategy and quantifiable evidence of the attainment of objectives for each activity.

(g) *Budget.* (Total: 10 points) The extent to which the proposed costs are necessary and reasonable in relation to the project objectives and scope.

(Authority: 20 U.S.C. 1057–1059, 1066–1069f)

§ 607.23 What special funding consideration does the Secretary provide?

(a) If funds are available to fund only one additional planning grant and each of the next fundable applications has received the same number of points under § 607.21, the Secretary awards additional points, up to a maximum of two points, to any of those applicants that—

(1) Has an endowment fund of which the current market value, per full-time equivalent enrolled student, is less than the average current market value of the endowment funds, per full-time equivalent enrolled student, at similar type institutions; (one point) or

(2) Has expenditures for library materials per full-time equivalent enrolled student which is less than the average expenditure for library materials per full-time equivalent

enrolled student at similar type institutions. (one point)

(b) If funds are available to fund only one additional development grant and each of the next fundable applications has received the same number of points under § 607.22, the Secretary will award additional points, up to a maximum of three points, to any of those applicants that—

(1) Has an endowment fund of which the current market value, per full-time equivalent enrolled student, is less than the average current market value of the endowment funds, per full-time equivalent enrolled student, at similar type institutions; (one point)

(2) Has expenditures of library materials per full-time equivalent enrolled student which is less than the average expenditure for library materials per full-time equivalent enrolled student at similar type institutions (one point); or

(3) Propose to carry out one or more of the following activities—

(i) Faculty development;

(ii) Funds and administrative management;

(iii) Development and improvement of academic programs;

(iv) Acquisition of equipment for use in strengthening management and academic programs;

(v) Joint use of facilities; and

(vi) Student services. (one point)

(c) For the purpose of paragraphs (a) and (b) of this section, the Secretary considers that there are four types of institutions:

(1) Public junior or community colleges.

(2) Private nonprofit junior or community colleges.

(3) Public institutions that provide an educational program for which a bachelor's degree is awarded.

(4) Private nonprofit institutions that provide an educational program for which a bachelor's degree is awarded.

(d) Among applications submitted to carry out cooperative arrangement grants, the Secretary gives priority to those applications where the cooperative arrangment is georgraphically and economically sound or will benefit the applicant.

(e) As used in this section, an endowment fund does not include any fund established or supported under 34 CFR Part 628.

(f) Each year, the Secretary provides propsective applicants with the average expenditure of endowment funds and library materials per full-time equivalent student.

(Authority: 20 U.S.C. 1057 and 1069)

Subpart D—What Conditions Must a Grantee Meet?

§ 607.30 What are allowable costs and what are the limitations on allowable costs?

(a) *Allowable costs.* Except as provided in paragraphs (b) and (c) of this section, a grantee may expend grant funds for activities that are related to carrying out the allowable activities included in its approved application.

(b) *Supplement and not supplant.* Grant funds shall be used so that they supplement and, to the extent practical, increase the funds that would otherwise be available for the activities to be carried out under the grant and in no case supplant those funds.

(c) *Limitations on allowable costs.* A grantee may not use an indirect cost rate to determine allowable costs under its grant.

(Authority: 20 U.S.C. 1057–1059 and 1066)

§ 607.31 How does a grantee maintain its eligibility?

(a) A grantee must maintain its eligibility under the requirements contained in § 607.2, other than § 607.2(a)(1) and § 607.2(a)(2), for the duration of the grant period.

(b) An institution that receives a grant for more than one year shall annually submit to the Secretary an assurance that it continues to meet the eligibility requirements described in paragraph (a) of this section.

(Authority: 20 U.S.C. 1057–1059, 1066–1069f)

Subpart E—What Compliance Procedures Does the Secretary Use?

§ 607.40 What penalties does the Secretary use?

In addition to any other penalty, any grantee or any officer, director, agent, or employee thereof (or anyone connected in any capacity therewith) who embezzles, willfully misapplies, misappropriates, or obtains by fraud any of the funds awarded under the Strengthening Institutions Program is subject to a fine or imprisonment or both.

(Authority: 20 U.S.C. 1069d)

[FR Doc. 87-13218 Filed 6-9-87; 8:45 am]

BILLING CODE 4000-01-M

Federal Register

Wednesday
June 10, 1987

Part VIII

Department of Education

34 CFR Parts 608 and 609

Strengthening Historically Black Colleges and Universities Program and Strengthening Historically Black Graduate Institutions Program; Proposed Rule

DEPARTMENT OF EDUCATION

34 CFR Parts 608 and 609

Strengthening Historically Black Colleges and Universities Program and Strengthening Historically Black Graduate Institutions Program

AGENCY: Department of Education.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Secretary proposes regulations to govern the Strengthening Historically Black Colleges and Universities (HBCU) Program and the Strengthening Historically Black Graduate Institutions Program. The regulations are needed to implement these two new programs, each of which is authorized under Part B of Title III of the Higher Education Act of 1965 (HEA) as amended by the Higher Education Act Amendments of 1986, Pub. L. 99-498.

DATES: Comments must be received on or before July 10, 1987.

ADDRESSES: All comments concerning these proposed regulations should be addressed to: Dr. Caroline J. Gillin, Director, Institutional Aid Programs, U.S. Department of Education, L'Enfant Plaza, Post Office Box 23868, Washington, DC 20024.

A copy of any comments that concern information collection requirements should also be sent to the Office of Management and Budget at the address listed in the Paperwork Reduction Act section of this preamble.

FOR FURTHER INFORMATION CONTACT: Dr. Caroline J. Gillin, Telephone: (202) 732-3308.

SUPPLEMENTARY INFORMATION:

Strengthening Historically Black Colleges and Universities Program

Under the Strengthening Historically Black Colleges and Universities Program, the Secretary awards grants to historically Black colleges and universities (HBCUs) to assist these institutions in establishing and strengthening their physical plants, academic resources and student services so that they may continue to participate in fulfilling the goals of equality of educational opportunity. The grant amount is based upon a statutory formula which is set forth in § 608.31 of the proposed regulations. The grant activities are also set out in the statute and are repeated in § 608.10.

Section 322(2) of the HEA defines those institutions that are eligible to receive grants under the HBCU Program. In order to receive a grant under the HBCU Program under that section, an institution must be accredited or preaccredited and it must be either a junior of community college or an institution which provides an edcuational program for which it awards a bachelor's degree. In addition, the institition must qualify as a historically black college or university that was established before 1964 and has a principal mission that was, and is, the education of Black Americans.

In interpreting section 322(2) to determine whether an institution qualifies as a historically black college or university that was established before 1964 and has a principal mission that was, and is, the education of Black Americans, the Secretary has relied heavily on the intent of the Congress as expressed in the legislative history of that section. Section 322(2) was authorized by the Higher Education Amendments of 1986, Pub. L. 99-498.

Senator Paul Simon of Illinois, the principal author of the HBCU Program, indicated on the Senate floor during the enactment of the Higher Education Amendments of 1986 that it was his view that "105 historically black colleges and universities, and the College of the Virgin Islands" satisfy the program eligibility criteria relating to being a historically black college or university that was established before 1964 and having a principal mission that was, and is, the education of Black Americans. Senator Simon described the source for the identity of these institutions as follows:

> The Secretary of Education's Advisory Committee on Black Colleges and Universities and Black Higher Education, which ceased to exist on June 1982, identified 105 historically black colleges and universities that were originally created to educate the freed slaves. Each of these institutions meets the definition contained in section 322(2), however, although both Howard University and the University of the District of Columbia would be excluded under the special rule in section 324(f) . . . . In addition, the College of the Virgin Islands meets the statutory eligibility criteria, and as the principal author of this legislation, I specifically intended that the College of the Virgin Islands be considered as an historically black college . . . .,

Congressional Record of June 3, 1986, p. S6589.

The Senate Committee on Labor and Human Resources, when it reported its version of the Higher Education Amendments of 1986 to the Senate, also indicated that each of the "105 historically black colleges and universities" listed by the Advisory Committee qualified as being a historically black college or university that was established before 1964 and having a principal mission that was, and is, the education of Black Americans. The committee report stated:

> The Secretary of Education's Advisory Committee on Black Colleges and Universities and Black Higher Education (which ceased to exist in June 1982) identified 105 historically black colleges and universities that were originally created to educate freed slaves. Each of these institutions meets the definition contained in Section 322 (2), however, both Howard University and the University of the District of Columbia would be excluded under the Special Rule in Section 324 (f).

Senate Report 99-296, 99 Cong. 2d Sess. p. 23, May 12, 1986.

Accordingly, in § 608.2(b) of the proposed regulations, the Secretary has listed each institution that qualifies as a historically black college or university that was established before 1964 and has a principal mission that was, and is, the education of Black Americans. The list includes the College of the Virgin Islands and 98 of the 105 institutions identified by the Secretary's Advisory Committee on Black Colleges and Universities and Black Higher Education. The seven institutions not listed have closed.

Six of the institutions on the list, however, are ineligible to receive a grant under this part. Four of the institutions are currently ineligible because they are not accredited or preaccredited. These four institutions are:

Allen University, Columbia, South Carolina
Bishop College, Dallas, Texas
Clinton Junior College, Rock Hill, South Carolina
Prentiss Normal & Industrial Institute, Prentiss, Mississippi

Two of the institutions on the list, Atlanta University and Meharry Medical School, are ineligible because they do not provide educational programs for which bachelor's degrees are awarded and they do not qualify as junior or community colleges. These two institutions, however, are two of the five institutions that are eligible to receive grants under the Strengthening Historically Black Graduate Institutions Program.

Three of the institutions on the list will not be awarded grant funds. One institution, the Interdenominational Theological Center in Atlanta, Georgia is a divinity school and would not be able to spend grant funds without violating section 357(1) of the HEA which provides that funds appropriated for the HBCU Program "may not be used for a school or department of divinity or any religious worship or sectarian instruction." Finally, as a result of the

separate appropriations for Howard University and the University of the District of Columbia, those two institutions will not receive grants under special rules contained in section 324 (f) of the HEA.

Strengthening Historically Black Graduate Institutions Program

Under the Strengthening Historically Black Graduate Institutions Program, the Secretary may award grants to Morehouse School of Medicine, Meharry Medical School, Charles R. Drew Postgraduate Medical School, Atlanta University, and Tuskegee Institute School of Veterinary Medicine to assist these institutions in establishing and strengthening their physical plants, development offices, endowment funds, academic resources and student services so that they may continue to participate in fulfilling the goal of equality of educational opportunity in graduate education. If the Secretary awards a grant of less than $500,000, no cost sharing on the part of the grantee is required. However, if the Secretary awards a grant in excess of $500,000, the grantee must match the entire grant award on a dollar for dollar basis.

Strengthening Historically Black Colleges and Universities Program and Strengthening Historically Black Graduate Institutions Program

Under each program, and in contrast to the Strengthening Institutions Program authorized under Part A of Title III of the HEA as well as the Strengthening Institutions and Special Needs Programs previously authorized under Title III of the HEA, a grantee may use grant funds to carry out operational as well as developmental activities. However, a grantee may only use grant funds to supplement and in no case supplant funds that would otherwise be made available by the institution for grant activities.

Grantees under each program are subject to the cost principles contained in Part II of Appendix D to 34 CFR Part 74. Grantees should bear in mind that the cost principles that govern the charging of employee salaries against a grant are contained in section I.2 of Part II of Appendix D to 34 CFR Part 74. That section incorporates the provisions of section J. 7. b. and d. of Part I of Appendix D to 34 CFR Part 74.

Grantees under each program must provide for the conduct of a compliance and financial audit of any grant funds by a qualified, independent organization or person in accordance with standards established by the Comptroller General of the United States for the audit of governmental organizations, programs, and functions. The audits must be conducted at least once every two years, covering the period since the previous audit, and a grantee must submit the audit to the Secretary. However, if a grantee is audited under Chapter 75 of title 31 of the United States Code, the Secretary considers that audit to satisfy the audit requirements of these programs.

Executive Order 12291

These proposed regulations have been reviewed in accordance with Executive Order 12291. They are not classified as major because they do not meet the criteria for major regulations established in the order.

Regulatory Flexibility Act Certification

The Secretary certifies that these proposed regulations would not have a significant economic impact on a substantial number of small entities. While some small institutions of higher education would be affected by these regulations, they would not be subject to excessive regulatory burdens or unnecessary Federal supervision. The regulations would impose minimal requirements to ensure the proper expenditure of project funds.

Paperwork Reduction Act of 1980

Sections 608.20, 609.20, 608.41 and 609.42 contain information collection requirements. As required by section 3504(h) of the Paperwork Reduction Act of 1980, the Department of Education will submit a copy of these proposed regulations to the Office of Management and Budget (OMB) for its review. Organizations and individuals desiring to submit comments on the information collection requirements should direct them to the Office of Information and Regulatory Affairs, OMB, Room 3002, New Executive Office Building, Washington, DC 20503; Attention: Joseph F. Lackey, Jr.

Invitation to Comment

Interested persons are invited to submit comments and recommendations regarding these proposed regulations.

All comments submitted in response to these proposed regulations will be available for public inspection, during and after the comment period, in Room 3045, Regional Office Building #3, 7th & D Streets, SW., Washington, DC, between the hours of 8:30 a.m. and 4:00 p.m., Monday through Friday of each week, except Federal holidays.

To assist the Department in complying with the specific requirements of Executive Order 12291 and the Paperwork Reduction Act of 1980 and their overall requirement of reducing regulatory burden, the Secretary invites comments on whether there may be further opportunities to reduce any regulatory burdens found in these proposed regulations.

Assessment of Educational Impact

The Secretary particularly requests comments on whether the regulations in this document would require transmission of information that is being gathered by or is available from any other agency or authority of the United States.

List of Subjects in 34 CFR Parts 608 and 609

College and universities, Education, Reporting and recordkeeping requirements.

(Catalog of Federal Domestic Assistance Number 84.031B—Strengthening Historically Black Colleges and Universities Program).

Dated: May 18, 1987.

William J. Bennett,

Secretary of Education.

The Secretary of Education proposes to amend Title 34 of the Code of Federal Regulations by adding new Parts 608 and 609 to read as follows:

PART 608—STRENGTHENING HISTORICALLY BLACK COLLEGES AND UNIVERSITIES PROGRAM

Subpart A—General

Sec.

Subpart B—What Kind of Projects Does the Secretary Fund?

Subpart C—How Does an Eligible Institution Apply for a Grant?

Subpart D—How Does the Secretary Make a Grant?

Subpart E—What Conditions Must a Grantee Meet?

Authority: 20 U.S.C. 1060 through 1063a, 1063c and 1069c, unless otherwise noted.

Subpart A—General

§ 608.1 What is the Strengthening Historically Black Colleges and Universities (HBCU) Program?

The Strengthening Historically Black Colleges and Universities Program, hereafter called the HBCU Program, provides grants to Historically Black Colleges and Universities (HBCUs) to assist these institutions in establishing and strengthening their physical plants, academic resources and student services so that they may continue to participate in fulfilling the goal of equality of educational opportunity.

(Authority: 20 U.S.C. 1060)

§ 608.2 What institutions are eligible to receive a grant under the HBCU Program?

(a) To be eligible to receive a grant under this part, an institution of higher education must—

(1) Be a historically black college or university;

(2) Have been established before 1964;

(3) Have a principal mission that was, and is, the education of Black Americans; and

(4) Be, and have been for five academic years preceding the academic year for which it seeks a grant under this part—

(i) Legally authorized by the State in which it is located to be a junior or community college or to provide an educational program for which it awards a bachelor's degree; and

(ii) Accredited or preaccredited by a nationally recognized accrediting agency or association that the Secretary has determined to be a reliable authority as to the quality of education or training offered.

(b) The Secretary has determined that the following institutions satisfy the requirements contained in paragraphs (a)(1) through (a)(3) of this section.

Alabama	
Alabama A & M University	Huntsville.
Alabama State University	Montgomery.
Concordia College	Selma.
S.D. Bishop State Junior College	Mobile.
Lawson State College	Birmingham.
Miles College	Birmingham.
Oakwood College	Huntsville.
Selma University	Selma.
Stillman College	Tuscaloosa.
Talladega University	Talladega.
Tuskegee University	Tuskegee.

Arkansas	
Arkansas Baptist College	Little Rock.
Philander Smith College	Little Rock.
Shorter College	Little Rock.
University of Arkansas at Pine Bluff	Pine Bluff.

Delaware	
Delaware State College	Dover.

District of Columbia	
Howard University	
University of the District of Columbia	

Florida	
Bethune Cookman College	Daytona Beach.
Edward Waters College	Jacksonville.
Florida A & M University	Tallahassee.
Florida Memorial College	Miami.

Georgia	
Albany State College	Albany.
Atlanta University	Atlanta.
Clark College	Atlanta.
Fort Valley State College	Fort Valley.
Interdenominational Theological Center.	Atlanta.
Morehouse College	Atlanta.
Morris Brown College	Atlanta.
Paine College	Augusta.
Savannah State College	Savannah.
Spelman College	Atlanta.

Kentucky	
Kentucky State University	Frankfort.

Louisiana	
Dillard University	New Orleans.
Grambling State University	Grambling.
Southern University A & M College	Baton Rouge.
Southern University at New Orleans	New Orleans.
Xavier University of Louisiana	New Orleans.

Maryland	
Bowie State College	Bowie.
Coppin State College	Baltimore.
Morgan State University	Baltimore.
University of Maryland-Eastern Shore	Princess Anne.

Mississippi	
Alcorn State University	Lorman.
Coahoma Junior College	Clarksdale.
Jackson State University	Jackson.
Mary Holmes College	West Point.
Mississippi Valley State University	Itta Bena.
Prentiss Normal and Industrial Institute.	Prentiss.
Rust College	Holly Springs.
Tougaloo College	Tougaloo.
Utica Junior College	Utica.

Missouri	
Lincoln University	Jefferson City.

North Carolina	
Barber-Scotia College	Concord.
Bennett College	Greensboro.
Elizabeth City State University	Elizabeth City.
Fayetteville State University	Fayetteville.
Johnson C. Smith University	Charlotte.
Livingstone College	Salisbury.
North Carolina A & T State University.	Greensboro.
North Carolina Central University	Durham.
Saint Augustine's College	Raleigh.
Shaw University	Raleigh.
Winston-Salem State University	Winston Salem.

Ohio	
Central State University	Wilberforce.
Wilberforce University	Wilberforce.

Oklahoma	
Langston University	Langston.

Pennsylvania	
Cheyney State University	Cheyney.
Lincoln University	Lincoln.

South Carolina	
Allen University	Columbia.
Benedict College	Columbia.
Claflin College	Orangeburg.
Clinton Junior College	Rock Hill.
Morris College	Sumter.
South Carolina State College	Orangeburg.
Voorhees College	Denmark.

Tennessee	
Fisk University	Nashville.
Knoxville College	Knoxville.
Lane College	Jackson.
LeMoyne-Owen College	Memphis.
Meharry Medical College	Nashville.
Morristown College	Morristown.
Tennessee State University	Nashville.

Texas	
Bishop College	Dallas.
Huston-Tillotson College	Austin.
Jarvis Christian College	Hawkins.
Paul Quinn College	Waco.
Prairie View A & M University	Prairie View.
Southwestern Christian College	Terrell.
Texas College	Tyler.
Texas Southern University	Houston.
Wiley College	Marshall.

U.S. Virgin Islands	
College of the Virgin Islands	St. Thomas.

Virginia	
Hampton University	Hampton.
Norfolk State University	Norfolk.
Saint Paul's College	Lawrenceville.
Virginia State University	Petersburg.
Virginia Union University	Richmond.

West Virginia	
Bluefield State College	Bluefield.
West Virginia State College	Institute.

(c) If an institution has merged with another institution, and, as a result of the merger, would not otherwise qualify to receive a grant under this part, that institution may nevertheless qualify to receive a grant under this part if—

(1) The institution would have qualified to recive a grant before the merger; and

(2) The institution was eligible to receive a grant under the Special Needs Program in any fiscal year prior to fiscal year 1986.

(d) For the purpose of paragraph (a)(4)(ii) of this section, the Secretary publishes a list in the **Federal Register** of the nationally recognized accrediting agencies and associations that he has determined to be a reliable authority as to the quality of education or training offered.

(e) Notwithstanding any other provision of this section, for each fiscal year—

(1) The University of the District of Columbia is eligible to receive a grant under this part only if the amount of the

grant it is scheduled to receive under § 608.31 exceeds the amount it is scheduled to receive in the same fiscal year under the District of Columbia Self-Government and Governmental Reorganization Act; and

(2) Howard University is eligible to receive a grant under this part only if the amount of the grant it is scheduled to receive under § 608.31 exceeds the amount it is scheduled to receive in the same fiscal year under the Act of March 2, 1867, 20 U.S.C. 123.

(Authority, 20 U.S.C. 1061 and 1063(f); House Report 99–861, 99th Cong., 2d Sess. p. 367, September 22, 1986; Senate Report 99–296, 99th Cong., 2d Sess. p. 23, May 12, 1986; Cong. Rec. of June 3, 1986, pp. 6588–6589)

§ 608.3 What regulations apply?

The following regulations apply to this part:

(a) The Department of Education General Administrative Regulations (EDGAR) in 34 CFR Part 74 (Administration of Grants); the following sections in 34 CFR Part 75 (Direct Grant Programs): §§ 75.1–75.104, 75.125–75.129, 75.190–75.192, 75.500, 75.524–75.534, 75.580–75.903; 34 CFR Part 77 (Definitions That Apply to Department Regulations); and 34 CFR Part 78 (Education Appeal Board).

(b) The regulations in this part.

(Authority: 20 U.S.C. 1060–1063a, 1063c)

§ 608.4 What definitions apply?

The following definitions apply to this part:

(a) *Definitions in EDGAR.* The folowing terms used in this part are defined in 34 CFR 77.1:

Applicant
Application
Award
Budget
EDGAR
Equipment
Fiscal year
Grant period
Private
Project
Project period
Public
Secretary

(b) The following definitions also apply to this part:

"Accredited" means the status of public recognition which a nationally recognized accrediting agency or association grants to an institution which meets certain established qualifications and educational standards.

"Graduate" means a student who has attended an institution for at least three semesters and fulfilled academic requirements for undergraduate studies in not more than five consecutive school years.

"Junior or community college" means an institution of higher education—

(1) That admits as regular students persons who are beyond the age of compulsory school attendance in the State in which the institution is located and who have the ability to benefit from the training offered by the institution;

(2) That does not provide an educational program for which it awards a bachelor's degree or an equivalent degree; and

(3) That provides an educational program of not less than 2 years that is acceptable for full credit toward such a degree; or offers a 2-year program in engineering, mathematics, or the physical or biological sciences, designed to prepare a student to work as a technician or at the semiprofessional level in engineering, scientific, or other technological fields requiring the understanding and application of basic engineering, scientific, or mathematical principles of knowledge.

"Pell Grant" means the grant program authorized by Title IV–A–1 of the Higher Education Act of 1965, as amended.

"Preaccredited" means a status, also called candidacy status, that a nationally recognized accrediting agency or association, recognized by the Secretary to grant that status, has accorded an unaccredited institution that is making reasonable progress toward accreditation.

"School year" means the period of time from July 1 of one calendar year through June 30 of the subsequent calendar year. (A "school year" is equivalent to an "award year" under the Pell Grant Program.)

Authority: (20 U.S.C. 1060–1063)

Subpart B—What Kind of Projects Does the Secretary Fund?

§ 608.10 What activities may be carried out under a grant?

(a) *Allowable activities.* Except as provided in paragraph (b) of this section, a grantee may carry out the following activities under this part—

(1) Purchase, rental, or lease of scientific or laboratory equipment for educational purposes, including instructional or research purposes;

(2) Construction, maintenance, renovation, and improvement in classroom, library, laboratory, and other instructional facilities;

(3) Support of faculty exchanges and faculty fellowships to assist these faculty members in attaining advanced degrees in their fields of instruction;

(4) Academic instruction in disciplines in which Black Americans are underrepresented;

(5) Purchase of library books, periodicals, microfilm, and other educational materials; and

(6) Tutoring, counseling, and student service programs designed to improve academic success.

(b) *Unallowable activities.* A grantee may not carry out the following activities under this part—

(1) Activities that are not included in the grantee's approved application;

(2) Activities that are inconsistent with any State plan of higher education that is applicable to the institution;

(3) Activities that are inconsistent with a State plan for desegregation of higher education that is applicable to the institution;

(4) Activities or services that relate to sectarian instruction or religious worship; and

(5) Activities provided by a school or department of divinity. For the purpose of this provision, a "school or department of divinity" means an institution, or a department of an institution, whose program is specifically for the education of students to prepare them to become ministers of religion or to enter upon some other religious vocation, or to prepare them to teach theological subjects.

(Authority: 20 U.S.C. 1062, 1063a and 1069c)

§ 608.11 What is the duration of a grant?

The Secretary may award a grant under this part for a period of up to five academic years.

(Authority: 20. U.S.C. 1063b(b))

Subpart C—How Does an Eligible Institution Apply for a Grant?

§ 608.20 What are the application requirements for a grant under this part?

In order to receive a grant under this part, an institution must submit an

application to the Secretary at such time and in such manner as the Secretary may prescribe. The application must contain—

(a) A description of the activities to be carried out with grant funds;

(b) A description of how the grant funds will be used so that they will supplement and, to the extent practical, increase the funds that would otherwise be made available for the activities to be carried out under the grant and in no case supplant those funds;

(c) An assurance that the institution will provide the Secretary with an annual report on the activities carried out under the grant;

(d) An assurance that the institution will provide for, and submit to the Secretary, the compliance and financial audit described in § 608.41;

(e) An assurance that the proposed activities in the application are in accordance with any State plan that is applicable to the institution;

(f) The number of graduates of the applicant institution during the school year immediately preceding the fiscal year for which grant funds are requested; and

(g) The percentage of graduates of the applicant institution who are in attendance at a graduate or professional school in a degree program in a discipline in which Blacks are underrepresented.

(Authority: 20 U.S.C. 1063, 1063a and 1066(b)(2))

Subpart D—How Does the Secretary Make a Grant?

§ 608.30 What is the procedure for approving and disapproving grant applications?

The Secretary approves any application which satisfies the requirements of § 608.20 and does not disapprove any application, or any modification of an application, without affording the applicant reasonable notice and opportunity for a hearing.

(Authority: 20 U.S.C. 1063a)

§ 608.31 How does the Secretary determine the amount of a grant?

(a) Except as provided in paragraph (b) of this section, for each fiscal year, the Secretary determines the amount of a grant under this part by—

(1) Multiplying fifty percent of the amount appropriated for the HBCU Program by the following fraction—

$$\frac{\text{Number of Pell Grant recipients at the applicant institution during the school year immediately preceding that fiscal year:}}{\text{Number of Pell Grant recipients at all applicant institutions during the school year immediately preceding that fiscal year;}}$$

(2) Multiplying twenty-five percent of the amount appropriated HBCU Program by the following fraction—

$$\frac{\text{Number of graduates of the applicant institution during the year immediately preceding that fiscal year;}}{}$$

(3) Multiplying twenty-five percent of the amount appropriated for the HBCU Program by the following fraction

$$\frac{\text{The percentage of graduates of the applicant institution who are in attendance at a graduate or professional school in a degree program in a discipline in which Blacks are underrepresented.}}{\text{The sum of the percentages of those graduates of all applicant institutions; and;}}$$

(4) Adding the amounts obtained in paragraphs (a)(1), (a)(2), and (a)(3) of this section.

(b) For the purpose of paragraph (a)(3)(of this section—

(1) The percentage of graduates of an applicant institution who are in attendance at a graduate or professional school in disciplines in which Blacks are underrepresented is measured by the following fraction:

$$\frac{\text{The number of graduates of an applicant institution who are in attendance at a graduate or professional school in disciplines in which Blacks are underrepresented}}{\text{The number of graduates in the graduating classes of the graduates included in the numerator;}}$$

(2) The Secretary considers that Blacks are underrepresented in a professional or academic discipline if the percentage of Blacks in that discipline is less than the percentage of Blacks in the general population of the United States; and

(3) The Secretary, through a notice in the **Federal Register**, notifies prospective applicants of the disciplines in which Blacks are underrepresented.

(c) Notwithstanding the formula in paragraph (a) of this section—

(1) For each fiscal year, each eligible institution with an approved application must receive at least $350,000; and

(2) If the amount appropriated for a fiscal year for the HBCU Program is insufficient to provide $350,00 to each eligible institution with an approved application, each grant is ratably reduced. If additional funds become available for the HBCU Program during a fiscal year, each grant is increased on the same basis as it was decreased until the grant amount reached $350,000.

(d) The amount of any grant that the Secretary determines will not be required by a grantee for the period for which the grant was made is available for reallotment by the Secretary during that period to other eligible institutions under the formula set forth in paragraph (a) of this section.

(Authority: 20 U.S.C. 1063)

Subpart E—What Conditions Must A Grantee Meet?

§ 608.40 What are allowable costs and what are the limitations on allowable costs?

(a) *Allowable costs.* Except as provided in paragraph (b) of this section, a grantee may expend grant funds for activities that are related to carrying out the allowable activities included in its approved application.

(b) *Supplement and not supplant.* Grant funds shall be used so that they supplement, and to the extent practical, increase the funds that would otherwise be available for the activities to be carried out under the grant, and in no case supplant those funds.

(c) *Limitations on allowable costs.* A grantee may not—

(1) Spend more than fifty percent of its grant award in each fiscal year for costs relating to constructing or maintaining a classroom, library, laboratory, or other instructional facility; or

(2) Use an indirect cost rate to determine allowable costs under its grant.

(Authority: 20 U.S.C. 1062)

§ 608.41 What are the audit and repayment requirements?

(a)(1) A grantee shall provide for the conduct of a compliance and financial audit of any funds it receives under this part of a qualified, independent organization or person in accordance with the *Standards for Audit of Governmental Organizations, Programs, Activities, and Functions,* 1981 revision, established by the Comptroller General of the United States.

(2) The grantee shall have an audit conducted at least once every two years, covering the period since the previous audit, and the grantee shall submit the audit to the Secretary.

(3) If a grantee is audited under Chapter 75 of Title 31 of the United States Code, the Secretary considers that audit to satisfy the requirements of paragarph (a)(1) of this section.

(b) An institution awarded a grant under this part must submit to the Education Department Inspector Gerneral three copies of the audit required in paragraph (a) of this section within 6 months after completion of the audit.

(c) Any individual or firm conducting an audit described in § 626.42(a) shall give the Department of Education's Inspector General access to records or other documents necessary to review the results of the audit.

(d) A grantee shall repay to the Treasury of the United States any grant funds it received that it did not expend or use to carry out the allowable activities included in its approved application within ten years following the date of the initial grant it received under this part.

(Authority: 20 U.S.C. 1063a and 1063c)

§ 608.42 Under what conditions does the Secretary terminate a grant?

If an institution loses its accreditation status, or its State authority, the Secretary terminates any existing grant that was made under this part.

(Authority: 20 U.S.C. 1063a)

PART 609—STRENGTHENING HISTORICALLY BLACK GRADUATE INSTITUTIONS PROGRAM

Subpart A—General

Sec.

Subpart B—What kind of Project Does the Secretary Fund?

Subpart C—How Does an Eligible Institution Apply for a Grant?

Subpart D—How Does the Secretary Make a Grant?

Subpart E—What Conditions Must a Grantee Meet?

Authority: 20 U.S.C. 1063b and 1069c, unless otherwise noted.

Subpart A—General

§ 609.1 What is the Strengthening Historically Black Graduate Institutions Program?

The Strengthening Historically Black Graduate Institutions Program provides grants to the institutions listed in § 609.2 to assist these institutions in establishing and strengthening their physical plants, development offices, endowment funds, academic resources and student services so that they may continue to participate in fulfilling the goal of equality of educational opportunity in graduate education.

(Authority: 20 U.S.C. 1060 and 1063b)

§ 609.2 What institutions are eligible to receive a grant under this Part?

(a) An institution listed in paragraph (b) of this section is eligible to receive a grant under this part if the Secretary determines that the institution is making a substantial contribution to the legal, medical, dental, veterinary or other graduate education opportunities for Black Americans.

(b) The institutions referred to in paragraph (a) of this section are—

(1) Morehouse School of Medicine;

(2) Meharry Medical School;

(3) Charles R. Drew Postgraduate Medical School;

(4) Atlanta University; and

(5) Tuskegee Institute School of Veterinary Medicine.

(Authority: 20 U.S.C. 1063b(e))

§ 609.3 What regulations apply?

The following regulations apply to this part:

(a) The Department of Education General Administrative Regulations (EDGAR) in 34 CFR Part 74 (Administration of Grants); the following sections in 34 Part 75 (Direct Grant Programs) §§ 75.1–75.104, 75.125–75.129, 75.190–75.192, 75.500, 75.524–75.534, 75.580–75.903; 34 CFR Part 77 (Definitions That Apply to Department Regulations); and 34 CFR Part 78 (Education Appeal Board).

(b) The regulations in this part.

(Authority: 20 U.S.C. 1063b)

§ 609.4 What definitions apply?

The following definitions apply to this part: *Definitions in EDGAR.* The following terms used in this part are defined in 34 CFR Part 77.1:

Applicant
Application
Award
Budget
EDGAR
Equipment
Fiscal year

Grant period
Private
Project
Project period
Public
Secretary

Subpart B—What kind of Projects Does the Secretary Fund?

§ 609.10 What activities may be carried out under a grant?

(a) *Allowable activities.* Except as provided in paragraph (b) of this section, a grantee may carry out the following activities under this part—

(1) Purchase, rental, or lease of scientific or laboratory equipment for educational purposes, including instructional or research purposes;

(2) Construction, maintenance, renovation, and improvement in classroom, library, laboratory, and other instructional facilities;

(3) Support of faculty exchanges and faculty fellowships to assist the faculty members in attaining advanced degrees in their fields of instruction;

(4) Academic instruction in disciplines in which Black Americans are underrepresented;

(5) Purchase of library books, periodicals, microfilm, and other educational materials;

(6) Tutoring, counseling, and student service programs designed to improve academic success.

(7) Establishing or improving a development office to strengthen and increase contributions from alumni and the private sector; and

(8) Establishing and maintaining an institutional endowment under 34 CFR 628 to facilitate financial independence.

(b) *Unallowable activities.* A grantee may not carry out the following activities under this part—

(1) Activities that are not included in the grantee's approved application;

(2) Activities that are inconsistent with any State plan of higher education that is applicable to the institution;

(3) Activities that are inconsistent with a State plan for desegregation of higher education that is applicable to the institution;

(4) Activities or services that relate to sectarian instruction or religious worship; and

(5) Activities provided by a school or department of divinity. For the purpose of this provision, a "school or department of divinity" means an institution, or a department of an institution, whose program is specifically for the education of students to prepare them to become ministers of religion or to enter upon some other religious vocation, or to prepare them to teach theological subjects.

(Authority: 20 U.S.C. 1062, 1063a and 1069c)

§ 609.11 What is the duration of a grant?

The Secretary may award a grant under this part for a period of up to five academic years.

(Authority: 20 U.S.C. 1063b)(b))

Subpart C—How Does an Eligible Institution Apply for a Grant?

§ 609.20 What are the application requirements for a grant under this part?

In order to receive a grant under this part, an institution must submit an application to the Secretary at such time and in such manner as the Secretary may prescribe. The application must contain—

(a) A description of the activities to be carried out with grant funds and how those activities will improve graduate educational opportunities for Black and low-income students and lead to greater financial independence for the applicant;

(b) A description of how the applicant is making a substantial contribution to the legal, medical, dental, veterinary or other graduate education opportunities for Black Americans;

(c) In the case of an application for a grant in excess of $500,000, an assurance that 50 percent of the costs of all the activities to be carried out under the grant will come from non-Federal sources; and

(d) A description of how the grant funds will be used so that they will supplement, and to the extent practical, increase the funds that would otherwise be made available for the activities to be carried out under the grant and in no case supplant those funds, for the activities described in § 609.10(a)(1) through (a)(8).

(e) An assurance that the proposed activities in the application are in accordance with any State plan that is applicable to the institution.

(Authority: 20 U.S.C. 1063d and 1066(b)(2))

Subpart D—How Does the Secretary Make a Grant?

§ 609.30 How does the Secretary determine the amount of a grant?

(a) For each year for which funds are appropriated for this program, the Secretary awards a grant to each eligible institution that submits an approved application.

(b) If the sum of the approved applications does not exceed the amount appropriated, the Secretary awards a grant in the amount requested and approved.

(c) If the sum of the approved requests exceeds the sum appropriated, each grant is reduced as the Secretary considers appropriate, so that the sum of the approved grants equals the amount appropriated.

(Authority: 20 U.S.C. 1063b)

Subpart E—What Conditions Must a Grantee Meet?

§609.40 What are the matching requirements?

If an institution receives a grant in excess of $500,000, it must spend non-Federal funds to meet the cost of at least 50 percent of the activities approved in its application.

(Authority: 20 U.S.C. 1063b)

§ 609.41 What are allowable costs and what are the limitations on allowable costs?

(a) *Allowable costs.* Except as provided in paragraph (b) of this section, a grantee may expand grant funds for activities that are reasonably related to carrying out the allowable activities included in its approved application.

(b) *Supplement and not supplant.* Grant funds shall be used so that they supplement, and to the extent practical, increase the funds that would otherwise be available for the activities to be carried out under the grant, and in no case supplant those funds.

(c) *Limitations on allowable costs.* A grantee may not—

(1) Spend more than fifty percent of its grant award in each fiscal year for costs relating to constructing or maintaining a classroom, library, laboratory, or other instructional facility.

(2) Use an indirect cost rate to determine allowable costs under its grant.

(Authority: 20 U.S.C. 1062 and 1063b)

§ 609.42 What are the audit and repayment requirements?

(a)(1) A grantee shall provide for the conduct of a compliance and financial audit of any funds it receives under this part by a qualified, independent organization or person in accordance with the *Standards for Audit of Governmental Organizations, Programs, Activities, and Functions,* 1981 revision, established by the Comptroller General of the United States.

(2) The grantee shall have an audit conducted at least once every two years, covering the period since the previous audit, and the grantee shall submit the audit to the Secretary.

(3) If a grantee is audited under Chapter 75 of Title 31 of the United States Code, the Secretary considers

that audit to satisfy the requirements of paragraph (a)(1) of this section.

(b) An institution awarded a grant under this part must submit to the Education Department Inspector General three copies of the audit required in paragraph (a) of this section within 6 months after completion of the audit.

(c) Any individual or firm conducting an audit described in § 626.42(a) shall give the Department of Education's Inspector General access to records or other documents necessary to review the results of the audit.

(d) A grantee shall repay to the Treasury of the United States any grant funds it received that it did not expend or use to carry out the allowable activities included in its approved application within ten years following the date of the initial grant it received under this part.

(Authority: 20 U.S.C. 1063a and 1063c)

[FR Doc. 87-13219 Filed 6-9-87; 8:45 am]
BILLING CODE 4000-01-M

Federal Register

Wednesday
June 10, 1987

Part IX

Department of Education

34 CFR Part 649

Patricia Roberts Harris Fellowships Program; Final Regulations and Notice of Proposed Stipend Levels

DEPARTMENT OF EDUCATION

34 CFR Part 649

Patricia Roberts Harris Fellowships Program

AGENCY: Department of Education.

ACTION: Final regulations.

SUMMARY: The Secretary issues final regulations for the Patricia Roberts Harris Fellowships Program, formerly called the Fellowships for Graduate and Professional Study Program. There are two components of this program—Graduate and Professional Study, and Education for the Public Service. These amendments are needed to conform the regulations to the changes made by the Higher Education Amendments of 1986. These regulatory amendments will, among other things, eliminate the Domestic Mining and Mineral and Mineral Fuel Conservation Fellowships.

EFFECTIVE DATE: These regulations take effect either 45 days after publication in the **Federal Register** or later if the Congress takes certain adjournments. If you want to know the effective date of these regulations, call or write the U.S. Department of Education contact persons.

FOR FURTHER INFORMATION CONTACT: Dr. Charles H. Miller or Barbara J. Harvey, Patricia Roberts Harris Fellowships Program, Office of Postsecondary Education, U.S. Department of Education, 400 Maryland Avenue, SW., Room 3022, ROB-3, Washington, DC 20202. Telephone: (202) 732-4395 or (202) 732-4863.

SUPPLEMENTARY INFORMATION: The Secretary amends the regulations for the Patricia Roberts Harris Fellowships Program which provides Federal financial assistance to enable institutions of higher education to make fellowship awards in post-baccalaureate education to graduate and professional students who demonstrate financial need.

On October 17, 1986, the President signed into law amendments to Title IX, Part B of the Higher Education Act of 1965, as amended. The revisions in these regulations are necessary to incorporate a number of significant changes in the program as mandated by the Act. As a result of these amendments, the following changes have been made to the regulations:

The name of the Graduate and Professional Study Program is changed to the Patricia Roberts Harris Fellowships Program.

A definition of financial need for fellowship recipients under the Title IX program is added as a provision that no stipend may exceed $10,000 or the demonstrated level of financial need, whichever is less. In addition, financial need must be measured and determined under Part F, Title IV of the Act. In a separate Notice, the Secretary is proposing to establish a maximum stipend level for the Patricia Roberts Harris Fellowships Program of $6,900 for the 1987-88 academic year. This proposed change would increase the stipend level by $2,400 from the previous level of $4,500 for academic year 1986-87. This new maximum stipend level of $6,900 would enable the Secretary to conduct a new competition for both components of the program—Graduate and Professional Study and Education for the Public Service—and also to provide increased stipends to continuing fellows.

The Domestic Mining and Mineral and Mineral Fuel Conservation Fellowships are no longer provided under the program.

Institutional payments are to approximate amounts paid under similar fellowship programs administered through the National Science Foundation and other similar agencies.

No minimum grant amount for institutions is provided.

A requirement is added that the amount expended for categories of Patricia Roberts Harris Fellowships for each fiscal year is not less than the amount expended for each category in fiscal year 1985.

Waiver of Proposed Rulemaking

Under section 431(b)(2)(A) of the General Education Provisions Act (20 U.S.C. 1232(b)(2)(A), and the Administrative Procedure Act, 5 U.S.C. 553, it is the practice of the Secretary to offer interested parties the opportunity to comment on proposed regulations.

Because these regulations merely incorporate mandatory statutory changes required by the Higher Education Amendments of 1986, public comments would have no effect on the content of these regulations. Therefore, the Secretary has determined that publication of a proposed rule is unnecessary and contrary to the public interest under 5 U.S.C. 553(b)(B).

Executive Order 12291

These regulations have been reviewed under Executive Order 12291. They are not classified as major because they do not meet the criteria for major regulations established in the order.

Paperwork Reduction Act of 1980

These regulations have been examined under the Paperwork Reduction Act of 1980 and have been found to contain no information collection requirements.

Assessment of Educational Impact

The Secretary has determined that the regulations in this document do not require transmission of information that is being gathered by or is available from any other agency or authority of the United States.

List of Subjects in 34 CFR Part 649

Colleges and universities, Education, Fellowships, Reporting and recordkeeping requirements.

Dated: May 12, 1987.

William J. Bennett,

Secretary of Education.

(Catalog of Federal Domestic Assistance Number 84.094B—Graduate and Professional Study Fellowships; 84-094C—Public Service Education Fellowships.)

PART 649—[AMENDED]

The Secretary amends Part 649 of Title 34 of the Code of Federal Regulations as follows:

1. The authority citation for Part 649 is revised to read as follows:

Authority: 20 U.S.C. 1134d to 1134f, unless otherwise noted.

2. The title of Part 649 is revised to read as follows:

PART 649—PATRICIA ROBERTS HARRIS FELLOWSHIPS PROGRAM

In Part 649, remove the words "underrepresented groups" and add, in their place, the words "traditionally underrepresented groups" in the following places:

(a) Section 649.4(b);

(b) Section 649.12(a)(2)(i), (a)(2)(iii), (b)(2)(i), (b)(2)(ii) (c)(1), (c)(2), (e), and (f); and

(c) Section 649.13(b).

4. In Part 649, remove the words "Graduate and professional Opportunity Fellowships" and add, in their place, the words "Graduate and Professional Study Fellowships" in the following places:

(a) Section 649.1(b)(1);

(b) Section 649.11(a)(1), (b), and (b)(1)(i); and

(c) Section 649.12(b)(2)(ii).

5. Section 649.1 is amended by removing the semi-colon at the end of paragraph (b)(1) and (b)(2) and by adding, in their place, a period, by removing paragraph (b)(3), by revising the section title and text in paragraph (a), and by adding a new paragraph (c), to read as follows:

§ 649.1 Patricia Roberts Harris Fellowships.

(a) Patricia Roberts Harris Fellowships—referred to in these regulations as the Fellowship Program—provides Federal assistance to enable institutions of higher education to make available fellowship awards in post-baccalaureate education to graduate and professional students who demonstrate financial need.

(Authority: 20 U.S.C. 1134d)

* * * * *

(c) Each recipient of an award under this program is to be known as a "Particia Roberts Harris Fellow."

* * * * *

6. Section 649.3 is revised to read as follows:

§ 649.3 Regulations that apply to the fellowship program.

The following regulations apply to this program:

(a) The Education Department General Administrative Regulations (EDGAR) in 34 CFR Part 74 (Administration of Grants), 34 CFR Part 75 (Direct Grant Programs), Part 77 (Definitions That Apply To Department Regulations), and Part 78 (Education Appeal Board), except that §§ 75.116, 75.117, and 75.232 are inapplicable to this program; and §§ 75.510–75.568 are inapplicable to the institutional allowances to institutions of higher education under this program.

(b) The regulations in this Part 649.

(Authority: 20 U.S.C. 1134d, 1134e)

7. Section 649.4(b) is amended by removing the definitions of "Domestic mining" and "Mineral and mineral fuel conservation", and revising the definitions "Fellow", "Financial need", and "Underrepresented groups" to read as follows:

§ 649.4 Definitions.

* * * * *

(b) * * *

"Fellow" means a recipient of a Patricia Roberts Harris Fellowship under this part.

* * * * *

"Financial need" means, for an academic year, the cost of attendance of a fellow minus the fellow's expected family contribution, as determined under Part F of Title IV of the Act.

* * * * *

"Traditionally underrepresented groups" means minorities and other groups, including women, who historically have been underrepresented in the specific graduate area of study or profession for which a fellowship is awarded.

* * * * *

8. Section 649.10(a) is amended by removing ", and 649.14," by adding "and" between "649.12" and "649.13" and by adding a period after "649.13", and by revising (b)(2) to read as follows:

§ 649.10 How to apply for funds.

* * * * *

(b) * * *

(2) Can demonstrate financial need.

* * * * *

9. Section 649.11 is amended by removing paragraphs (a)(3) and (b)(3), by redesigning paragraphs (b)(4) and (b)(5) as paragraphs (b)(3) and (b)(4), respectively, and by revising paragraphs (a)(1), (c)(3), and the introductory text of paragraph (b) to read as follows:

§ 649.11 How does the Secretary evaluate an application?

(a) *Funding reservations.* (1) The Secretary reserves funds for grants Fellowships under section 922(e) of the Act (referring to the amount the Secretary is required to expend for each category of fellowships) and applicable appropriation statutes.

* * * * *

(b) *Selection criteria.* Subject to the funding reservations, the Secretary—in determining whether to select an institution of higher education for a grant and how many fellowships to authorize under the grant—assesses an application on the basis of the criteria in § 649.12 for Graduate and Professional Study Fellowships and the criteria in § 649.13 for Public Service Education Fellowships.

* * * * *

(c) * * *

(3) An appropriate balance of fellowships with regard to academic areas, taking account of present and projected needs for highly trained individuals in all areas of education beyond secondary school and in other than academic career fields of high national priority.

* * * * *

§ 649.14 [Removed]

10. Section 649.14 is removed.

11. Section 649.30(c) is revised to read as follows:

§ 649.30 What are the criteria for selecting fellows?

* * * * *

(c) Plan to pursue—

(1) An academic career or some other professional career of importance in the academic area of study approved by the Secretary; or

(2) A career in public service.

* * * * *

12. In § 649.42, paragraph (b) is revised to read as follows:

§ 649.42 Fellowship conditions.

* * * * *

(b) Devote essentially full time to study or research (including acting as a teaching or research assistant as may be required as a condition to award of a degree) in the field in which the fellowship was awarded; and

* * * * *

13. In § 649.50, the first sentence in paragraph (a) is revised to read as follows:

§ 649.50 Amount of a fellowship.

(a) The maximum stipend that an institution may award to any fellow for a twelve-month period is $10,000, or the demonstrated level of the fellow's financial need, whichever is less. * * *

* * * * *

14. In § 649.51, paragraph (c) is amended by adding the words "and collects from" after the word "charges", and paragraph (a) is revised to read as follows:

§ 649.51 Institutional allowance.

(a) Under section 922(f) of the Act, the Secretary establishes and pays an institutional allowance for each fellowship in the same amount as is paid under similar fellowship programs administered through the National Science and other similar agencies.

* * * * *

15. Section 649.52 is revised by adding a new paragraph (c) to read as follows:

§ 649.52 Payment procedures.

* * * * *

(c) The Secretary does not award a fellowship under this part for study at a school or department of divinity.

* * * * *

[FR Doc. 87–13221 Filed 6–9–87; 8:45 am]

BILLING CODE 4000–01–M

DEPARTMENT OF EDUCATION

Patricia Roberts Harris Fellowships Program

AGENCY: Department of Education.

ACTION: Notice of Proposed Stipend Levels for the Patricia Roberts Harris Fellowships Program in Fiscal Year 1987.

SUMMARY: The Secretary proposes to establish a maximum twelve-month stipend level of $6,900 for fellowship recipients under the Patricia Roberts Harris Fellowships Program, Title IX, Part B of the Higher Education Act of 1965, as amended by the Higher Education Amendments of 1986, 20 U.S.C. 1134d to 1134f, during academic year 1987–88. The proposed maximum stipend level would provide current fellowship recipients with an increase in their stipend levels over the past academic year and would allow funding for new fellowships.

DATES: Comments must be received on or before July 10, 1987.

ADDRESSES: All written comments should be sent to Dr. Charles H. Miller, Senior Program Officer for Graduate Programs, Division of Higher Education Incentive Programs (Room 3022, ROB #3, MS 3327), Office of Postsecondary Education, U.S. Department of Education, 400 Maryland Avenue SW., Washington DC 20202.

FOR FURTHER INFORMATION CONTACT: Dr. Charles H. Miller, Telephone (202) 732–4395, or Barbara J. Harvey, Telephone (202) 732–4863.

SUPPLEMENTARY INFORMATION: Under the Patricia Roberts Harris Fellowships Program the Secretary makes available grants to institutions of higher education for fellowship awards in post-baccalaureate education to graduate and professional students who demonstrate financial need. There are two components of this program—Graduate and Professional Study, and Education for the Public Service.

Under the Higher Education Amendments of 1986, Pub. L. 99–498, the maximum amount of the student's fellowship stipend was increased from $4,500 to an amount not to exceed the lesser of $10,000 or the demonstrated level of financial need; the institutional allowance was set at the same level for fellowship programs administered by the National Science Foundation, resulting in an increase from $3,900 to $6,000.

The final regulations for the Patricia Roberts Harris Fellowships Program are being published in this issue of the **Federal Register.** The purpose of the final regulations is to implement Title IX, Part B of the Higher Education Act of 1965, as amended. These regulations were amended to reflect the statutory changes contained in the Higher Education Amendments of 1986. In the Fiscal Year 1987 Continuing Appropriations Act, Congress appropriated $11,750,000 for the Graduate and Professional Study component of this program and $2,500,000 for the Public Service Education component.

A maximum stipend level of $6,900 for the 1987–88 academic year is proposed, which will enable the Department to conduct a new competition in both components of the program and also to provide increased stipends to continuing fellows. This proposed action would increase the stipend level by $2,400 from the previous level of $4,500. Fellows who demonstrate financial need exceeding the amount of the stipend continue to be eligible for other available forms of federal financial assistance.

Invitation to Comment

Interested persons are invited to submit comments and recommendations regarding the stipend levels proposed in this notice. Written comments and recommendations may be sent to the address given at the beginning of this document. All comments submitted in response to this notice will be available for public inspection, during and after the comment period, in Room 3022, ROB–3, 7TH & D Streets, SW., Washington, DC between the hours of 8:30 a.m. and 4:00 p.m., Monday through Friday of each week except Federal holidays.

(Authority: 20 U.S.C. 1134d–f)

(Catalog of Federal Domestic Assistance Nos. 84.094B—Graduate and Professional Study Fellowships; 84–094C—Public Service Education Fellowships)

Dated: June 5, 1987.

William J. Bennett,

Secretary of Education.

[FR Doc. 87–13222 Filed 6–9–87; 8:45 am]

BILLING CODE 4000–01–M

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Vol. 52, No. 111

Wednesday, June 10, 1987

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